NEW JERSEY
KEEPING FAMILIES TOGETHER

PROGRAM MANUAL

NEW JERSEY DEPARTMENT OF
CHILDREN AND FAMILIES

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ACKNOWLEDGEMENTS

The NJ Keeping Families Together (NJ KFT) Program Model was adapted and refined by the New Jersey Department of Children and Families (NJ DCF). NJ DCF would like to thank a number of collaborative partners who contributed to the development of the NJ KFT Program Model, implementation supports, and participated in pilot testing. The NJ KFT Program Model would not be where it is today without the dedication, expertise, and significant time of staff from DCF; NJ KFT Provider Partners; Consultant stakeholders and NJ KFT families.

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[1] National Implementation Research Network at the Frank Porter Graham Child Development Institute. Available online at: https:nirn.fpg.unc.edu/

PURPOSE, ORGANIZATION, AND EXPECTATIONS

PURPOSE

Keeping Families Together, also known as NJ KFT or KFT, is a model of supportive housing and services designed for a subset of families involved with New Jersey Department of Children and Family's Division of Child Protection and Permanency. The purpose of the New Jersey Keeping Families Together (NJ KFT) Program Manual is to serve as a comprehensive resource that incorporates the framework, procedures, operational processes, and resources necessary for maintaining program fidelity to the NJ Keeping Families Together Program Model and carrying out service activities with consistency and excellence.

The NJ KFT Program Manual outlines how to implement services according to the best practices captured in the Practice Profile. It is designed to standardize the delivery of services across NJ KFT provider agencies. Standardization of service delivery also requires prudent judgment in working with the unique needs and circumstances of children and families. NJ KFT programs should remain reasonably flexible to the discovery of improvements and adaptations in service delivery that are not yet documented in the NJ KFT Program Manual. To ensure ongoing consistency of high-quality implementation, any improvements or adaptations must be discussed with the DCF team.

ORGANIZATION

This manual is organized into five (5) main sections, additional resources, and an appendix:

Section 100. Introduction to the NJ Keeping Families Together Program. This section offers history and background on how the program was refined and adapted. It also provides an overview of the NJ KFT Logic Model highlighting the expected outcomes, services, and resources needed to implement the model.

Section 200. NJ KFT Practice Model. This section focuses on the NJ KFT Practice Profile—outlining the Guiding Principles and Essential Functions of the NJ KFT Program Model. It describes the behavioral indicators that need to be present in order for the program to be successfully implemented by NJ KFT staff.

Section 300. NJ KFT Program Services. This section explores the NJ KFT Program Model's core services and phases of services delivery. It also highlights the necessary NJ KFT Practice Profile Essential Functions necessary to support service delivery.

Section 400. NJ KFT Administrative Operations. This section focuses on administrative functions that lead to successful operation of the NJ Keeping Families Together program. It highlights core staff, recruitment and selection processes along with training, supervision and coaching opportunities.

Section 500. NJ KFT Forms and Tools. This section includes standard program forms and tools necessary to implement a NJ KFT program. It includes checklists, handouts and marketing material, and evaluation and assessment forms.

Additional Resources. The program manual concludes with additional resources. This section contains research articles, suggested reading materials, and additional information related to implementing the NJ KFT Program Model.

Appendix. The program manual also includes an appendix containing more detailed background information, along with program documents and tools that support the delivery of the NJ KFT Program Model.

EXPECTATIONS

Agencies who contract with the NJ DCF to deliver the NJ KFT Program Model with families in New Jersey are expected to use this NJ KFT Program Manual as a guide for successful implementation and to achieve desired outcomes. It is critical that Provider Partners adhere to the practice and service standards outlined in this manual to ensure program fidelity, and ultimately, to support high quality implementation of NJ KFT in service to successful family outcomes.

For reference, a list of commonly used acronyms can be found below.

COMMONLY USED ACRONYMS

CPS—Child Protective Services

CSH—Corporation for Supportive Housing

CWS—Child Welfare Services

DCA—NJ Department of Community Affairs

DCF—NJ Department of Children and Families

DCP&P—Division of Child Protection and Permanency

DHS—Department of Human Services

DMHAS—Division of Mental Health and Addiction Services

EBI—Evidence Based Intervention

FEF—Frequently Encountered Families

KFT—Keeping Families Together (an existing service model)

NJ KFT—New Jersey Keeping Families Together (the model being referenced throughout this manual)

ORER—DCF's Office of Research, Evaluation and Reporting

OSD—DCF's Office of Strategic Development

Family Stories and Quotes

Stories and quotes from families who've participated in and/or staff who've implemented NJ KFT programming have been shared throughout this manual. They represent their own personal experiences or their accounts of families' experiences within the NJ KFT program. To ensure confidentiality, identifying information has been omitted.

"The program has given me the opportunity to think about my hopes and dreams. Not having to think about where my children will sleep or whether we can get into the house when we get home, is freeing."

SECTION 100

INTRODUCTION TO THE KEEPING FAMILIES TOGETHER PROGRAM

100
INTRODUCTION TO THE KEEPING FAMILIES TOGETHER PROGRAM

101 HISTORY AND BACKGROUND OF FAMILY SUPPORTIVE HOUSING

Family homelessness reaps devastating effects on families. National research shows that due to absent comprehensive intervention, these families often confront out-of-home placements for their children, family dissolution, ongoing substance abuse and mental health disorders, intergenerational poverty, and long-term homelessness. To fully address the complex needs of families with recurring child-welfare-involvement, housing instability, and other co-occurring challenges such as mental illness, substance use disorders, and domestic violence, a comprehensive model is needed.

The New Jersey Department of Children and Families (DCF) began investing in Keeping Families Together (KFT) to meet the needs and help change the trajectory of some of the most vulnerable child welfare involved families.[2] KFT is a model of supportive housing designed specifically for child welfare involved families with an array of co-occurring challenges. The goal of KFT is to keep families together and stably housed, reduce their child welfare involvement, and improve child and family well-being. KFT enables parents to provide a safe and stable home for their children, while families are provided with support and guidance to manage their lives and improve their overall well-being. To supplement housing subsidies, support services and case management is also provided. Supportive housing has been identified as an effective, evidence informed practice in stabilizing other vulnerable populations including adults with serious mental illness. Furthermore, a growing body of research indicates that stabilizing individuals in supportive housing can also reduce their use of expensive public crisis services such as emergency rooms, psychiatric hospitals, and jails (Swann-Jackson et al., 2010).

In 2007, New York City initiated the first KFT pilot. Most families enrolled in the pilot had either a history of substance abuse and/or mental health challenges, and all had long and complex trauma histories. Highlights from the independent evaluation of the pilot include (Swann-Jackson et al., 2010):

- 90% of the pilot families remained housed;
- 61% of child welfare cases closed in an average of 10 months after move-in;
- 100% of children returned to their families from foster care and stayed with their families;
- Abuse and neglect reports decreased dramatically; and,
- Roughly 63% had no further involvement with the child welfare system.

These results offered evidence that supportive housing can be an effective alternative to recurring child welfare system involvement and foster care placements among unstably housed families with high service needs. From 2012–2017, five sites across the country participated in a federally funded randomized controlled trial, Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System, to support the development of and increase the evidence base for supportive housing models as an intervention for high-needs child welfare-involved families. The study found that supportive housing increased housing stability, reduced homelessness, and reduced time to reunification among families who participated in the program compared to those who did not. For some sites, the program also reduced out-of-home placement and family separation (Pergamit et al., 2019).

[2] NJ KFT Program Brief available at http://1rooffamilies.org/wp-content/uploads/2016/10/NJ-KFT-two-pager_10.17.16.pdf

Thanks to critical partnerships and collaboration with the NJ Department of Human Services (DHS), NJ Department of Community Affairs (DCA), Corporation for Supportive Housing (CSH), Community Based Provider Partners, Private Developers and Landlords, the NJ KFT program has expanded from a pilot program serving ten families in Essex County to supporting over 600 families Statewide annually across 21 NJ counties.

102 PROGRAM DEVELOPMENT APPROACH

With the goal of creating a well-defined, replicable Keeping Families Together Program Model, NJ DCF, its contracted service providers, and consultants tapped into the principles of implementation science. The field of implementation science provides frameworks that assess and support the design and implementation of interventions toward the achievement of targeted outcomes (Fixsen et al., 2015; Powell et al., 2015). For innovative programs that are informed by literature, but have yet to be rigorously evaluated, the practice must be defined, implementation supports (training, coaching, fidelity tool, etc.) must be developed to support the practice, and data collection and evaluation must be established to inform ongoing practice improvements. These fundamental steps are necessary before the targeted outcomes can be achieved. NJ DCF systematically utilized the National Implementation Research Network's Active Implementation Framework and accompanying tools to organize and carry out program development for NJ KFT (Metz et al., 2017). For more information about how the Active Implementation Framework was used for NJ KFT program development, please see Appendix A.

103 NJ KFT PROGRAM MODEL

The NJ KFT Program Model provides supportive housing and services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing several other co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, and domestic violence. Once enrolled in the program, families have access to single and scattered site housing and a robust array of supportive services; including case planning with a NJ KFT team of clinical and case management staff and coordination of available community-based programming that include evidence-based and trauma-informed services. NJ KFT aims to achieve outcomes (intermediate and long-term) that include:

- Increased housing stability;
- Reduced recidivism within the child welfare system; and,
- Improved child and family well-being.

The NJ KFT Logic Model can be found in Figure 1 and Appendix B. The logic model highlights the vision, target population, resources, activities and outcomes (both intermediate and long-term) for the NJ KFT program.

FIGURE 1.
104 NJ DCF KFT LOGIC MODEL

NJ Keeping Families Together Logic Model

Vision: To keep families together by providing safe, permanent housing and evidence-based, trauma-informed support services to CP&P-involved families using a Housing First approach.

Name of Initiative: NJ Keeping Families Together (KFT)

Target Population: DCP&P involved families with high needs whose challenges with homelessness or housing instability place their children at risk of out-of-home placement or have delayed reunification with children currently in out-of-home placement.
*Specific requirements may vary across sites, "high needs" is generally defined as having multiple risk factors which may include substance use disorders, medical/mental health disorders, domestic violence, developmental disability (child), trauma history etc.

RESOURCES	ACTIVITIES	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Overarching Philosophy of "Whatever It Takes" **Staffing:** Program Manager/Supervisor KFT Practitioner KFT Champion Clinician **Collaborations:** Families DCP&P State Partners (DCA, DHS etc.) Housing Providers (Landlords, Developers etc.) Community Stakeholders **Data Collection Systems and Tools:** Agency data systems NJ DCF data portal *Tools Include:* Baseline Family Survey Services Survey Caregiver Satisfaction Survey **Assessment and Evaluation:** Collection of Assessment and Evaluation Tools that support Continuous Quality Improvement Practices **Training, Supervision and Coaching:** NJ KFT Training and Coaching Curriculum	**Intake and Enrollment** Includes assessing initial eligibility, facilitating the enrollment, and providing pre-tenancy services (i.e., initial voucher application and housing search/navigation). **Stabilization and Maintenance** Includes initial needs assessment and case planning to support the provision of the following, NJ KFT Services: – Case management* (Housing and Support Services) – Clinical Services (Individual and Group Sessions) – Concrete support ▪ One-time financial support (i.e., security deposits and other move-in costs) ▪ Transportation (limited availability) – Linkage to community-based resources **Moving On and Aftercare** **This may include the provision of employment, education support or other professional development services, as needed throughout the intervention.* ********** **Systems Collaboration with Key Partners** DCP&P – NJ KFT Provider partners engage in regular phone and in-person contact, participate in FTMs and case conferences, provide written collaterals (which includes progress notes and/or court reports), and other documentation, *as needed while the case remains open.* Housing Partners – NJ KFT Provider partners consistently engage with State agencies (i.e., NJ Department of Consumer Affairs), local Public Housing Authorities (PHAs), Landlords and Housing Developers, Continuums of Care (CoC) and a host of community partners to successfully support families in housing.	Improve housing stability for child welfare involvement families Improve caregiver reported well-being (parenting) Improve child reported well-being Improve family stability (i.e., income, employment)	Reduce recidivism within the child welfare system Integrate housing services within the child welfare services landscape

Assumptions:

- Per the Housing First approach, individuals and/or families are more likely to consistently meet their other needs when they are first provided with stable housing.
- Reducing fragmentation of services, including CPS, increases the likelihood that families will participate consistently in support services.
- NJ KFT staff will consistently implement the model as intended using a "whatever-it-takes" approach to support families.

In addition to the NJ KFT Logic Model, NJ DCF and a subset of NJ KFT providers developed the NJ KFT Practice Profile. As a tool for operationalizing a Program Model, Practice Profiles outline Guiding Principles and Essential Functions so that the program becomes "teachable, learnable, and doable" for staff (Metz, 2016). More information on the NJ KFT Practice Model can be found in Section 200 of this manual. The NJ KFT Practice Profile can also be found in Appendix C.

105 IMPLEMENTING AGENCIES

A list of NJ KFT implementing agencies with program staff contact information is available online at DCF | Family and Community Partnerships (nj.gov/dcf/about/divisions/dfcp/).

"Having someone going through the process with you, they (KFT staff) are always there… stopping by or just a phone call away. I don't feel like I'm doing this alone."

SECTION 200

NJ KFT PRACTICE MODEL

FAMILY STORY

"Mom completed substance use treatment and started culinary school. She graduated from culinary school with a clear passion for cooking and a new outlook on life with opportunities she did not previously think possible."

Mom and her two children (ages seven and one) were couch surfing at the time of enrollment, mom was also receiving substance use treatment. At intake, mom was open to NJ KFT services and very excited about the fresh start having a home would bring. Mom expressed how unsuccessful she had been previously with renting homes. There were barriers to finding a home due to mom's significant criminal history. With advocacy and collaboration, NJ KFT secured a home in mom's desired neighborhood with a landlord willing to give her a chance. There was an additional barrier, mom's PSE&G balance of over $4000.00. Mom had allowed family members to use her name as an arrangement for her staying in their home in previous years. Over the course of two years while mom was incarcerated, the family neglected to pay the PSE&G bill. NJ KFT advocated for assistance through various community agencies to resolve the utility arrears and move mom closer to a fresh start. **Mom moved into her new home six months after being referred to NJ KFT.** Throughout this journey, mom has had new life experiences and has made much personal progress, both as an individual and as a family. Mom later expanded her family, completed substance use treatment and began culinary school. She subsequently graduated from culinary school with a clear passion for cooking and a new outlook on life; with opportunities she did not previously think were possible. Mom continues to do very well living independently in her home with her three children and is still very engaged in NJ KFT services. Mom is also very vocal about how KFT has impacted her life, she is especially expressive about the importance of a team of people believing in her and giving her another chance to provide a home and stable life for her children.

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NJ KFT PRACTICE MODEL

201 NJ KFT PRACTICE PROFILE

The NJ KFT model comes to life in the NJ KFT Practice Profile (Appendix C). A Practice Profile is a tool for oper-ationalizing an intervention so that staff, supervisors, and directors across implementing agencies have clear understanding of the practice and there is consistency in implementation across practitioners and agencies. A Practice Profile includes Guiding Principles and Essential Functions.

202 NJ KFT GUIDING PRINCIPLES

Guiding principles are the philosophy, values, and principles that underlie the innovation. These guide the practitioner's decisions and ensure consistency, integrity, and sustainable effort across all practitioners (Fixsen et al., 2013; Metz et al., 2011).

There are six (6) NJ KFT Guiding Principles:

1. **Trusting Relationships**
2. **Housing Stability**
3. **Flexible**
4. **Voluntary Participation**
5. **Community Connections**
6. **Trauma and Evidence-Informed**

Trusting Relationships

Trusting relationships promote positive change and growth in families. Building and maintaining a trust-based relationship with family members is essential when working toward long-lasting change and positive outcomes. NJ KFT programs encourage open communication and cultivate trust with family members. Families should view NJ KFT programs as a source of support and assistance, both for routine services as well as in times of crisis. Every interaction with family members is an opportunity for further engagement and alliance-building.

Housing Stability

Housing stability is a platform for the teamwork that supports the well-being of families. Safe, stable and affordable housing provides a foundation for ongoing work with family members to set and work towards goals, including the sequencing of any services. NJ KFT programs work with families toward the overall goal of well-being and enhancing the family's ability to stay safely housed together, including helping family members heal from past traumas, build resilience, maintain the household, build finances, and be positively involved in their community. Practices, such as case conferencing and team clinical supervision, allow staff, supervisors and others who support family members and/or the supportive housing staff to share information, trouble-shoot difficult situations and reinforce a non-judgmental, supportive, and collaborative culture for the work.

Family members themselves are an integral part of the work to set and meet goals. Team meetings and other consistent modes of communication that meaningfully involve family members, should be used to further engage families in the ongoing assessment of progress, formulating goals and identifying when the team should expand, or contract based on family functioning. The team can be composed of professionals, representing formal supports, and non-professionals or informal supporters (relatives, friends, mentors) who are part of the family's circle. NJ KFT programs help family members build their circle of support by recognizing when relationships may not serve the family's goals and repairing others, as needed.

Flexible

There is flexibility in time and place for responding to the needs of families. The strength of the supportive housing model is that it provides unique opportunities to witness and respond to family circumstances in real time, sometimes on a daily basis, depending on the setting. The work of NJ KFT program staff goes beyond their desks. Meetings and collaborations with family members and others take place in the family's home, in schools, at local restaurants, or a parent or youth's workplaces. Often contact does not take place within the hours of nine to five.

Voluntary Participation

Services may not have time limits and are voluntary. The intensity of case management services is responsive to individual family need and circumstances. Families with complex and persistent service needs such as psychiatric or specialized medical care may need ongoing interventions. At times, NJ KFT programs will have to "dial-up" or increase the frequency and depth of family contact. At other times, NJ KFT programs will "dial down" or decrease the frequency of contact, recognizing that family members are making strides on their own. After achieving stability and improved outcomes, some families may no longer need or want as many formal supports or as much contact with NJ KFT programs. Such decisions should be made based upon mutual agreement between NJ KFT programs and family members; acknowledging and being responsive to a family's wishes, needs and progress. A family's trusting relationship with NJ KFT programs should reinforce a culture of open communication where a family's changing needs can be discussed and addressed; leaving the option open to request more help in the future if needed.

Community Connections

Community support is essential to helping families strengthen their own networks. Stress and isolation undermine physical and emotional health and positive parenting. NJ KFT programs actively work to build community and a culture of support and interaction among families involved with supportive housing, as well as with their neighbors who are not involved with the supportive housing program and the community at large. There will be families who have learned not to trust their neighbors and would rather engage in activities outside the immediate community, or not engage at all. Opportunities to connect to other families both in the supportive housing program and in the larger community should be offered on an ongoing basis. When considering community connections and support services, it is crucial for NJ KFT programs to understand that although support services have no established time limit, it is the expectation that many families will move on from supportive housing to less intensive service environments within the community. Valuing a moving on perspective is also crucial to ensuring scarce resources are applied most efficiently and facilitate NJ KFT families in moving on from supportive housing to affordable housing in the community, that is independent of services.

Trauma and Evidence-Informed

Strategies are trauma-informed. NJ KFT programs should be aware of the stressors with which many families live and the fact that many family members have been and continue to be exposed to a range of traumatic experiences for example: community violence, domestic violence, physical abuse, and complex grief. Exposure to multiple or prolonged traumatic events, typically beginning in early childhood and occurring within the primary caregiving system, produces complex trauma. NJ KFT programs should have the skills to identify and appropriately respond to trauma symptoms. Organizations, including supportive housing settings, have become much more aware of how the physical environment of office spaces and even administrative procedures may elicit negative responses related to a person's experiences with stress and trauma. Evidence-based or informed strategies, such as Motivational Interviewing, have a high probability of producing desired outcomes. Such strategies should be used by NJ KFT programs when providing services to family members. There are several directories of evidence-based therapeutic interventions and programs that can be consulted. But any intervention selected, whether it be from one of these directories or from other reliable sources and valid research, needs to be well matched to family strengths and needs in order to ensure its effectiveness. Interventions should make sense in the family's context and be complementary. Strategies are to be evaluated continuously to ensure their efficacy, or lack thereof, in order to make adaptations promptly and to put in place alternative strategies that may be more likely to succeed.

203 NJ KFT ESSENTIAL FUNCTIONS

Essential Functions define the role of practitioners and inform activities within each phase of work. Essential Functions provide a clear description of the features that must be present to say that the innovation is being used and to achieve outcomes ("Essential Functions" are sometimes called core components, active ingredients, or practice elements). Each Essential Function includes operational definitions describing the core activities associated with each Essential Function and allow the innovation to be "teachable, learnable, doable, and assessable" across a range of contexts (Fixsen et al., 2013; Metz, 2016; Metz et al., 2011).

There are seven (7) NJ KFT Essential Functions:

1. **Engaging**
2. **Assessing**
3. **Family Involved Teaming**
4. **Tracking and Adjusting**
5. **Advocating and Educating**
6. **Planning and Linking Services**
7. **Clinical Intervening**

203.1 Engaging

A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.

The following behavioral indicators are expected best practices for engaging in NJ KFT and should be demonstrated by staff in practice:

- **Initiates and maintains ongoing phone and in-person contact with family.**
  - Introduces self and program to DCP&P staff and stakeholders including resource parents, service providers, court/legal personnel and any additional family members, etc. and answers any emergent questions, preferably in a phone call.
  - Schedules appointments at a time and place that is convenient for the family and confirms visits, as needed.
  - Directly accessible to families 24 hours per day, seven days per week (including holidays), 365 days per year through the distribution of their cell phone number.
  - Discusses program participants roles and responsibilities which may include:
    - Clearly explaining expectations, policies and procedures of the program;
    - Clarifying time frames for working with the family; and/or
    - Informing the family of their rights and responsibilities.

  - Always engages in a transition process when staff changes. Process should include internal case conferencing and discussion of transfer details with family, DCP&P and relevant stakeholders.

- **Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate.**
  - Actively seeks opportunities to engage in regular communication with DCP&P and other stakeholders by phone, in person and/or written collateral contacts.
  - Invites DCP&P staff and stakeholders, with family's consent, to participate in Family Team Meetings and discusses their role and input in supporting the family.
  - Educates stakeholders about the Program Model and approach to working with the family.

- **Communicates in an open, honest, respectful and culturally sensitive manner.**
  - Approaches all interactions with families with openness and a nonjudgmental attitude by:
    - Listening without making assumptions;
    - Using language that everyone can understand;
    - Checking in frequently on communication styles and terms to ensure understanding;
    - Using empathy particularly when discussing sensitive topics through reflection, body language, and sensitive responses; and/or
    - Respecting the family's faith, culture and existing family rituals.
  - Consistently models honest and respectful communication by:
    - Communicating a sincere desire to be respectful ("I would like to be respectful, how should I address you?");
    - Addressing individuals by the name or title they request;
    - Responding to questions and describing situations honestly;
    - Providing relevant facts and information;
    - Making clear statements about what information or action is being requested of the family; and/or
    - Facilitating dialogue regarding how the requested information and actions will affect the situation and support the family.

- **Consistently employs Motivational Interviewing techniques.**
  - Employs active listening skills and focuses on showing both verbal and non-verbal signs of listening, to understand the parent.
  - Demonstrates a clear ability to respond with unconditional, positive regard to arguing, interrupting, negating (denial), ignoring or other parental behaviors.
  - Asks various open-ended questions that invite parent conversation as opposed to asking only yes/no response questions. For example, asks:
    - So, what brings you here today?
    - What are some of the ways that substance use affects your life?
    - What kinds of differences have you noticed in?
  - Makes reflective statements that restate the parent's comments using language that accurately clarifies and captures the meaning of the parent's communications and conveys to the parent an effort to understand the parent's point of view. Encourages the parent to explore or elaborate on a topic by:
    - Repeating exactly what the parent just stated;

    - Rephrasing by slightly rewording;
    - Paraphrasing by amplifying thoughts or feelings, using analogies, or making inferences;
    - Reflecting the parent's statements in an exaggerated manner;
    - Restating what the parent has said, but reminding them of the contrary things they have said previously; and,
    - Using reflective summary statements by selecting several pieces of parent information and combining them in a summary with the goal of inviting more exploration of material, to highlight ambivalence, or to shift focus by making a transition to another topic the parent is less ambivalent to exploring and changing.
  - Makes affirmations such as;
    - Using compliments or praise;
    - Acknowledging the parent's personal qualities, competencies or abilities that might promote change;
    - Recognizing effort or small steps taken by the parent to change; and/or
    - Using a positive reframe to affirm the parent (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the parent's persistence in trying to deal with his or her drug use problems and not giving up).
  - Reframes by acknowledging what the parent has said, but offers a different perspective.
  - Comes alongside the parent to take the side of no change to foster the parent's ambivalence and elicit change talk.

- **Consistently uses a family-centered approach.**
  - Recognizes the parent as a partner in the process and consistently uses a parent-centered approach.
  - Creates an environment that allows people to discuss family history and needs and communicates that family members are full partners in defining their needs, designing a plan of action to meet their needs, and reviewing their progress.
  - Uses strengths-based, solutions-focused, family centered, trauma informed strategies to elicit family input.
  - Demonstrates an understanding of the impact of family dynamics, intergenerational struggles, ethnicity, and culture on family functioning.
  - Incorporates family's ideas into planning processes and services.
  - Acknowledges existing family strengths and use them as the basis of growth and change.
  - Creates opportunities for families to discuss feelings and reactions about changes in family dynamics (i.e., DCP&P case goal, etc.).
  - Validates family's thoughts and feelings.
  - Recognizes non-verbal communication.

- **Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.**
  - Facilitates regular social events/activities (e.g., holiday parties, support groups, games) to promote social networking, interaction, and community-building among families.

203.2 Assessing

The ongoing process of acquiring the knowledge to understand strengths and needs of family members for effective decision making with family members and linkage to the most appropriate interventions. Identifying where family members are in the change process. Facilitating critical thinking and discussions with family members and their formal and informal team/supporters about the family's underlying needs, how they define problems and what success looks like. Assessments and service plans are focused on factors such as promoting child development, responsiveness to trauma, building protective and promotive factors for families.

The following behavioral indicators are expected best practices for assessing in NJ KFT and should be demonstrated by staff in practice:

- **Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.**

- **Uses a process to gather information.**
    - Communicates with the family and all providers involved (e.g., DCP&P, teachers, pediatricians, psy-chiatrists) to gather and document biopsychosocial information to guide the intervention by:
        - Asking questions by phone and/or during in person meetings with family, DCP&P workers and other collateral providers;
        - Reviewing DCP&P referral form and contacts DCP&P worker for family and case specific information;
        - Gathering information from relevant sources. This may include information from: case records, the child's school reports, substance use evaluations, medical reports, mental health assessments, and any other relevant information to inform the assessment of the family;
        - Observing family's interaction during contacts;
        - Conducting discussions appropriate to the developmental age, stage and capacity of the family member (such as those of a child or youth or cognitive delay for an adult); and,
        - Checking assumptions, listening and communicating understanding during conversations.
    - Inquires or guides a discussion about the risk factors driving the need for NJ KFT intervention (treatment), to develop a full understanding of the nature of the parent's difficulties and provide feedback using a non-judgmental, curious, collaborative parent-centered style.
    - Provides formal feedback if solicited by the parent or when seeking the parent's permission first.
    - Inquiries about family history, goals, and ongoing and evolving needs to collect and confirm information by exploring with family members:
        - Strengths, hopes, dreams, needs, goals, opportunities, solutions;
            - What is important in their present?
            - Where would they like to be "down the road?"
        - How, and to what extent, they identify with traditions of their cultures, communities, Tribes?;
        - Past encounters and experiences with service systems—services received, diagnoses given (CIRCL, 2000; Milton et al., 2017);
        - Who are the family's natural supports? (Examples include maternal and paternal relatives, close friends, and community resources and supports); and/or

    - Where are they in the change process at any given time? As a reminder, the stages include:
        - STAGE 1: Not Ready (Pre-contemplation)
        - STAGE 2: Getting Ready (Contemplation)
        - STAGE 3: Ready to Take Action (Preparation)
        - STAGE 4: Taking Action (Action)
        - STAGE 5: Ready to Maintain Gains (Maintenance)

- **Completes required assessment tools.**
    - Administers and accurately completes standardized assessment tools within designated time-frames, explaining to the family what is hoped to learn from them. Tools may include:
        - Bio-psychosocial assessment with parent and child;
        - Modified Arizona Self-Sufficiency Matrix; and/or
        - NJ KFT Baseline Survey and follow-up Services Survey at identified intervals.
    - Records the results of assessments in nonjudgmental language.

- **Synthesizes information and completes service plan.**
    - Uses formal and informal techniques to understand the strengths, interests, goals, needs, risks, stressors, and underlying issues of family members within the culture and context of the child and family.
    - Discusses observations and assessments with parents and elicits feedback regarding goal setting.
    - Uses the family's perspective and input, including collateral information from DCP&P and other providers, to develop an accurate picture of the family for planning and decision making.
    - Incorporates gathered information from reviews, inquiry, observations, parent feedback and assessments in a Service Plan which includes recommendation of the family's goals and behaviorally specific action items to achieve the identified goals.
    - Uses language and concepts the family uses and incorporates the family's strengths, resources, cultural perspective and solutions in all actions.
    - Assists with prioritizing family members' goals by initiating a discussion of the stages of change or level of motivation by helping the family members develop a rating of:
        - Importance: How important is the goal? Make it meaningful.
        - Confidence: How confident is the person that they will achieve the goal? Focus on the one the individual believes they could achieve first. (As one achieves simpler goals, it builds confidence and empowers to tackle more difficult ones.)
        - Readiness or commitment: Discusses ambivalence in detail or explicitly facilitates a costs/benefits analysis with parent input concerning change versus remaining the same. Specific techniques used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons.

- **Continually assesses and updates the Service Plan at regular intervals.**
    - Continues to assess throughout the intervention to determine if adjustments are needed during the intervention (e.g., review family's continued safety, growth and development).
    - Reviews the Service Plan at least every three months or as necessary to determine progress, update goals, and in consultation with the larger team determine whether it is appropriate to change the intensity of services.

203.3 Family Involved Teaming

A deliberate and structured approach to involving youth and families in decision-making through facilitated meetings of family members, their identified supports and professionals working with the family. Building a network of support with and for family members that consists of both non-professional and professionals, as needed, who work together to help family members meet their goals.

Identifying and defining the roles of all teams within the larger support network. Collaborating and coordinating across systems with and for families. Recognizing and appreciating the strength and support that a family's community, cultural and other natural relationships can provide. Establishing shared commitment and accountability with family members and others taking on their roles and responsibilities, holding themselves and others accountable for meeting goals. Creating an environment for psychologically safe, open and honest communication with the family and their formal and informal supports, facilitating continuous dialogue about the quality of services and adjustments needed. Collaborating within individual and between all the various teams, involving all components of the family's support system at all levels. Respectful and meaningful collaboration with families (and community partners) to achieve shared goals.

The following behavioral indicators are expected best practices for family involved teaming in NJ KFT and should be demonstrated by staff in practice:

- **Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.**
    - Recognizes that the team members come from diverse places.
    - Collaboratively identifies a support network made up of teams of informal and formal supports and ascertains the specific roles that individuals on the team can play, over time, to strengthen and support the family.
        - Informal support teams may include natural and extended family and cultural, community and/or Tribal, and other family identified supports.
        - Formal support teams may include external support/service providers serving the family including therapists, counselors, life coaches, medical professionals, teachers/childcare staff, other State agencies etc.
    - Continuously convenes, engages and supports the family's formal and informal teams.
    - Engages in ongoing communication about confidentiality and the implications for inclusion of informal and formal supports at team meetings.
    - Demonstrates respect to caregivers by having candid discussions and developing shared understanding with caregivers about their rights, role and expectations as parents and tenants.
    - Facilitates continuous dialogue with the family and their team members regarding how the agreed-upon supports and plans are working and reinforces the roles of the team members.
    - Incorporates family strengths, resources, cultural perspective and solutions in all decision-making, case planning, reports, meeting notes and other documents.
    - Celebrates success and accomplishments; no matter how small.
    - Supports the family's skill development in utilizing both formal and informal supports as a part of their team.

- Documents results of communications used in practice and service adjustments.
- Convenes the family to facilitate collaboration around the development of goals and implementation of services.
    - In the case of reunification, the goal may be to obtain information (e.g., child's health, routines, discipline techniques) to support the child's transition home.

- **Collaborates with DCP&P and community partners.**
    - Maintains a minimum of once monthly contact (via telephone or in-person) with DCP&P staff, should the family have an open case.
    - Networks with community partners to share ideas, expertise, challenges and solutions.
    - Involves community partners in planning meetings and considers their service recommendations, as appropriate, when goal setting and planning with the family.
    - Defines clear roles for each member of the team including DCP&P and other collaborative staff so that all team members are working towards a common goal for the family.

- **Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.**
    - Conducts family planning meetings which include:
        - Discussing family's progress;
        - Updating goals; and,
        - Determining if changes in service intensity are appropriate.
    - Attends and actively participates in DCP&P case conferences, Family Team Meetings (FTMs), and/or other child and family meetings, as needed and/or appropriate.

203.4 Tracking and Adjusting

Following up on the intervention delivery processes through regular communication with family members and service providers to understand progress being made, barriers encountered, and changing family circumstances. Regularly updating service needs assessments and individualized service plans to reflect the changing service needs and goals of family members.

The following behavioral indicators are expected best practices for tracking and adjusting in NJ KFT and should be demonstrated by staff in practice:

- **Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.**
    - Creates and gathers progress assessments from all parties and reviews that information with families.
    - Identifies and resolves service delivery issues, overcoming barriers and adjusting strategies, as needed.
    - Facilitates adjustments to plans and services based on family and support team discussions, assessments, and decisions.
    - Understands and monitors family progress, identifies emergent needs and makes adjustments to plans when necessary.
    - Addresses known risks to reduce/avert crises.
    - Works with family to identify needs and attend to them in planning efforts with all team members.
    - Ensures safety plans are in place when needed.

- **Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.**
    - Highlights contradictions and inconsistencies in the parent's behavior or stated goals, values, and self-perceptions.
    - Attempts to raise the parent's awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the parent.
    - Engages the parent in a frank discussion of perceived discrepancies and help the parent consider options to regain equilibrium by asking the parent to:
        - Look into the future and imagine a changed life under certain conditions (e.g., absence of drug abuse, if married with children);
        - Look back and recall periods of better functioning in contrast to the present circumstances; and/or
        - Consider the worst possible scenario resulting from their use or the best possible consequences resulting from trying to change.

203.5 Advocating and Educating

Speaking up for families and serving as a role model in order to support them in strengthening their family, meeting their needs, finding their voice, and developing their ability to advocate for themselves. Coordinating with the family's formal and informal advocates to assist the family to find their own solutions. Encouraging, supporting, and providing opportunities for family members to actively share their voice, offer solutions, act as leaders and be central in assessment, planning, and decisions about their lives. Helping families advocate for themselves and others for system and policy improvements.

Supporting the development of increased knowledge and skills needed to follow through with the identified goals. These goals could include parenting, home management, mental health, nutrition, self-care, etc.

The following behavioral indicators are expected best practices for advocating and educating in NJ KFT and should be demonstrated by staff in practice:

- **Advocates on behalf of parents/families as necessary.**
    - Supports the family's interests and needs at schools, courts, social service organizations, etc. to ensure that the family's voice is heard.
    - Reframes other's expectations or ideas about the family and communicates the family's strengths.
    - Communicates with other service providers involved with the family (with family's written consent) by advocating on behalf of the family's strengths and current needs for support.
    - Understands assertive communication skills and when to best utilize these skills to advocate for the family's needs.
    - Links families with professional or peer advocates when requested and includes the family's support persons and advocates on the team.

- **Supports the family in advocating for themselves.**
    - Teaches families to advocate for themselves through modeling, role playing, and coaching.
    - Assists family members in identifying and voicing their concerns and needs through regular assessment.
    - Coaches families to advocate for themselves through modeling self-advocacy, problem-solving, persistence and supports them in navigating systems effectively.
    - Teaches family members assertive communication skills and encouraging them to utilize these skills.
    - Supports family members in developing and sharing their own stories and "lived experiences" by:
        - Showing genuine interest;
        - Utilizing reflective listening;
        - Encouraging family members to share experiences during FTMs when comfortable;
        - Considers family members experts on their families; and/or
        - Encourages and supports family members to give input and provide feedback on processes and interventions which impact them.
    - Considers family members experts on their families.
    - Encourages and supports family members to give input and provide feedback on processes and interventions which impact them.

- **Promotes macro/system's level advocacy.**
  - Considers family members as the experts on the NJ KFT program by asking for consistent feedback and taking concerns seriously.
  - Encourages and supports family members in taking leadership roles and ownership in the program.
  - Provides opportunities for families to participate in organizational and system level advocacy through providing information on who they can contact and encouraging them to write letters, make phone calls, complete surveys, and participate in community events related to these systems.
  - Supports families in identifying and advocating for positive system and policy changes in their community by providing information on who they can contact and encouraging them to write letters, make phone calls, complete surveys, and participate in community events related to these systems.

- **Educates and supports skills development with families.**
  - Utilizes strategies requiring direct action/activity by the participant to practice the development of skills or acquisition of knowledge.
  - Adapts communication style to the needs of different participants, depending on their age, culture, ability, and learning style.
  - Provides educational material prior to meetings, when appropriate, and explains it in terms that are both accessible and meaningful to the family members.
  - Researches the local housing market and available community resources.
  - Demonstrates resourcefulness and creativity in planning interventions and teaching skills to families using various methods (e.g. use of therapeutic videos, games, handouts, worksheets, crafts, etc.).
  - Inquires about the family's progress during follow-up visits and obtains feedback on use of new skills.
  - Makes accessible resources available to support the family (such as specific assistance funds, public library resources) to reinforce skill-based activities.
  - Provides information on how family members can increase their knowledge and skills independently.
  - Encourages and supports parents to incorporate and demonstrate skills they have learned or developed to meet the needs of their child(ren).
  - Educates families about their tenancy rights and responsibilities and relationship building with landlords.
  - Provides tenancy skills support (e.g., budgeting and bill payment, lease observance, housekeeping, social skills, relationship building to encourage positive interactions with landlords and neighbors).
  - Empowers families by teaching how to search for and access community resources they may need.

203.6 Planning and Linking Services

Collaborate with family to develop appropriate family-centered/driven goals that are attainable within identified timeframes. Without agreed-upon goals and plans, families may only reach out when in crisis. Some common areas for goal setting in supportive housing include: Maintaining Housing (budgeting, physical maintenance, being a good neighbor, etc.), Substance Use, Daily Living Skills, Legal Concerns, Vocation/employment, Education, Family/Parenting, Childcare/school, Leisure/socialization, Medical/health, Spirituality.

Supporting the development of increased knowledge and skills needed to follow through with the identified goals. These goals could include parenting, home management, mental health, nutrition, self-care, etc.

The following behavioral indicators are expected best practices for planning and linking services in NJ KFT and should be demonstrated by staff in practice:

- **Assists the family in developing and executing a detailed service plan.**
  - Seeks guidance from the parent or acts as though sessions are a joint effort as opposed to one in which the practitioner consistently is in control by:
    - Emphasizing the (greater) importance of the parent's perspective and decisions about if and how to change; and
    - Making explicit statements that verbalize respect for the parent's autonomy and personal choice.
  - Facilitates discussion that includes the following areas: (1) the desired changes, (2) reasons for wanting to make these changes, (3) steps to make the changes, (4) people available to support the change plan, (5) impediments or obstacles to change and how to address them, and (6) methods of determining whether the plan has worked.
  - Identifies, in collaboration with family, two to four goals at a time with the intent to improve housing stability and family functioning. Each goal should have a minimum of two to three measurable objectives and interventions specific to the parent's needs.
  - Clarifies individual family member goals and collective family goals and attending to both.
  - Develops goals that are clearly delineated and defined in behaviorally specific language that are achievable within the identified timeframe.
  - Encourages open and ongoing dialogue and clarifies each family members desire for themselves versus imposing his/her own expectations for family members.
  - Elicits parent self-motivational statements or "change talk," or any type of discussion about change by:
    - Asking questions or making comments designed to promote greater awareness/concern for a problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change;
    - Asking the parent about how other people view the parent's behavior as concerning or problematic and how these concerns by others impact the parent's motivation for change; and/or
    - Initiating a more formal discussion of the stages of change or level of motivation by helping the parent develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened. In brief, capturing somewhat more directive means for eliciting a parent's change talk and addressing a parent's commitment to change.

- **Researches and connects families to community resources/supports most closely suited to the family's needs.**
  - Utilizes specific assistance to parents funding and resources to meet the families' needs or alleviate stress.
  - Provides referrals and information, actively links families through in-person visits, attends meetings and appointments, and completes applications for services, etc.
  - Connects and re-connects family members to formal and informal services and supports, cultural practices and traditions that can assist them with healing and recovery and meeting other goals.
  - Supports and encourages caregivers in participating in activities unrelated to their role as a parent in efforts to promote self-care and managing stress.
  - Explores potential barriers and coaches parent(s) on strategies to resolve.
  - Expresses confidence in the parent's ability to achieve his/her goals through affirming the parent by:
    - Using compliments or praise;
    - Acknowledging the parent's personal qualities, competencies or abilities that might promote change;
    - Recognizing effort or small steps taken by the parent to change; and/or
    - Using a positive reframe to affirm the parent (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the parent's persistence in trying to deal with his or her drug use problems and not giving up).

203.7 Clinical Intervening

Purposeful use of evidence based/informed approaches intended to help families identify and process emotions and practice positive coping skills.

The following behavioral indicators are expected best practices for clinical intervening in NJ KFT and should be demonstrated by staff in practice:

- **Promotes behavioral change through clinical interventions.**
  - Consistently employs Motivational Interviewing techniques.
  - Uses trauma-informed therapeutic approaches to assist and support family members.
  - Uses clinical expertise to observe, document and evaluate parent-child interactions.
  - Addresses concerns and supports family goals with a focus on decreasing family conflict, improving communication, developing the parent's ability to manage child's behaviors and decreasing high risk factors within the family.
  - Directly intervenes with children and models parenting techniques and skills to promote healthy attachment and increased child wellbeing.
  - Assesses and normalizes child's coping skills.
  - Provides feedback and positive reinforcement on parenting skills and interactions.
  - Educates parents on child development.
  - Observes how the parent responds to and uses information provided and aligns frequency of intervening to parental needs and skills.
  - Empowers and allows parents to be the lead in caring for their children with support as needed.
  - Coaches' parents to meet the needs of their children, while being careful not to undermine their authority and confidence in their parenting role.

"When I was actively using, I remember my son walking past me on the street with his friends, he acted like he didn't know who I was. He was embarrassed. My older children grew up seeing me as an addict. I don't want that for my youngest or my newborn. I get to be there for them, I get another chance to get it right."

SECTION 300

NJ KFT PROGRAM SERVICES

FAMILY STORY

" ...we (NJ KFT providers) are noticing major improvements in the children's behavior. Dad has made monumental strides in a relatively short period of time."

At the time of initial referral dad was in a homeless shelter after completing inpatient drug treatment with his two daughters. Just before the scheduled move-in, dad experienced a significant relapse. This delayed the move to their new home and dad returned to inpatient treatment. Over time, dad gained insight, and recognized the delayed move was necessary for the long-term success of the family. Dad completed inpatient treatment and the family moved into their new home. Now, dad regularly attends intensive outpatient treatment, in addition to participating in NJ KFT services. Dad plans to begin individual therapy with the NJ KFT clinician in the near future as they get settled in their new home. The children are involved in therapy with the NJ KFT clinician and we (KFT providers) are noticing major improvements in their behavior. Dad has made monumental strides in a short period of time.

300
NJ KFT PROGRAM SERVICES

This section provides a detailed description of the NJ KFT program services. It describes the activities and essential functions required to be delivered within each phase of service delivery. It is critical that all providers adhere to the service standards outlined in this section to ensure NJ KFT model fidelity both internally within their program and more broadly across the entire intervention and provider network.

This section begins with a visual depiction of the NJ KFT service delivery flowchart. For each phase of the service delivery process, it highlights the actions for staff to take and the timelines for completion of tasks during each phase of the service delivery process.

This section also describes the program eligibility criteria, referral, enrollment, and intake process. The section highlights the underpinnings of service phases and attends to the continuum of NJ KFT services from stabilization and maintenance to Moving On and Aftercare. It underscores the importance of NJ KFT teams working collaboratively with DCP&P, families, and other community partners alike to effectively support implementation. The section highlights these key alliances and emphasizes the importance of service linkage to ensure families' unique needs and challenges are addressed. Finally, this section describes how families typically move on from the NJ KFT program and related transition planning.

Forms that are referenced but not shown in Section 300 can be found in Section 500 and/or the Appendix of the NJ KFT Program Manual.

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REFERRAL AND PRE-ENROLLMENT

The DCP&P worker makes the initial referral on behalf of the family to the KFT local office liaison, often the DCP&P RDS. The KFT local office liaison partners with the KFT program lead (this person manages the KFT program within the DCF Central Office) to finalize referral information, complete the KFT screening tool and confirm the family's program eligibility.

If eligible, the KFT program lead notifies the KFT local office liaison and KFT Provider team to move forward with the initial case conference.

If ineligible, the DCP&P team assesses the family for alternate supports and resources.

INITIAL CASE CONFERENCE

The KFT Provider team completes the initial case conference with the DCP&P local office to gather additional background information (family's case history and any updates since the initial screening) to confirm the family's eligibility.

If eligible,the DCP&P case manager provides a referral packet (completed referral form, the family's case plan, and all supporting documents) to the KFT team.

The KFT Provider team discusses necessary forms/documentation and schedules ongoing communication with the DCP&P team to facilitate documentation gathering and next steps.

If ineligible, the DCP&P case manager notifies the family and moves forward with alternate support services. The KFT Provider team does make contact with the family if they are deemed ineligible during the initial case conference.

The KFT team contacts the family to schedule an introductory/enrollment meeting in partnership with DCP&P.

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INTAKE AND ENROLLMENT

The KFT Provider team meets with the family. The team explains the KFT program, informs the family of the process and completes an initial assessment of the family's immediate needs (this may include safety and other basic needs). The family decides whether they want to move forward with KFT services.

If yes, the KFT Provider team initiates services; Housing Case Management and Support Services.

If the family declines KFT, the KFT Practictioner notifies the DCP&P team; who will assess the family for alternate supports and/or resources.

HOUSING AND CASE MANAGEMENT SERVICES

The KFT Practitioner begins housing case management services with the family.

The KFT and DCP&P teams in collaboration with the family, complete a series of meetings/calls, and other communication, to complete the voucher application.

(This process includes gathering supporting documents for all household members).

The KFT Practitioner collects and emails all documentation to the KFT Supervisor, who submits the voucher application to DCA Central Office.

The DCA Central Office reviews the application packet for eligibility and completes required background check(s).

If the DCA Central Office denies the application, the KFT Practitioner informs the family and DCP&P team immediately.*

KFT team provides alternative housing resources and DCP&P supports the family in accessing alternate supports and programs.

*Note: all application denials should be disussed with the KFT program lead ahead of family notification.

When the application notifies the local field office who then notifies the family of approval and schedules a voucher briefing meeting.

At voucher briefing meeting, the family receives the housing voucher and can now begin searching for housing. The meeting includes the KFT parent, DCA field office staff and the KFT Practitioner.

SUPPORT SERVICES

The KFT Provider team begins support services with the family.

Note, all KFT services are voluntary for the family though not for the KFT Provider team.

If the family agrees to services, the KFT Provider team completes corresponding assessments to guide service planning and delivery (i.e. standardized individual and family assessments).

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The KFT Practitioner assists the family with finding a unit in the community.

If a unit is not secured within the DCA required initial housing search timeframe (60 days), the KFT Practitioner submits a written request for extension on behalf of (or in collaboration with) the family.

Note: If housing is not secured within 120 days, the family runs the risk of losing the housing voucher.

After the family selects a unit, the KFT practitoner works to ensure the landlord receives all required forms from DCA (including the Request for Tenancy Form (RFT)). The KFT Practitioner works in partnership with the parent and landlord to complete and return the RFT, and other required forms, to DCA.

After receiving the RFT, the DCA team conducts an inspection of the unit.

If the unit fails, the DCA team provides the landlord with a list of deficiencies and the landlord is given 30 days to remedy the concerns. If the concerns are not addressed, the family works with the KFT Provider team to identify another unit.

When the unit passes inspections, the landlord and DCA execute a Housing Assistance Payment (HAP) contract.The landlord and parent also executes a lease agreement. Prior to move in, the KFT Practitioner supports the family with the security deposit (this may be from KFT funding and/or community based resources).

The family receives the keys to the unit and moves into their new home.

The KFT Provider team supports the family with moving in, furnishing the unit and settling into their new home.

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STABILIZATION AND MAINTENANCE

The KFT Provider team engages the family by offering an array of services that include: case management, in-home visits, therapeutic services (individual and family), group sessions and referral/linkage to community-based supports.

Note: all KFT services are voluntary for the family though not for the KFT Provider team. The frequency of service provision is guided by a variety of factors (including family need, readiness for change, etc.).

In addition to services, the KFT Provider team also coordinates the ongoing collaboration of system partners serving the family (including DCP&P, Board of Social Services, Juvenile Justice, etc.) to support housing stability and well-being.

SUPPORT SERVICES: HOUSING

The KFT Practitioner facilities housing services activities that consist of the following:

- ongoing tenancy supports including planning, housing search, security deposits, case management, landlord engagement, and eviction prevention.

SUPPORT SERVICES: WELL-BEING AND COMMUNITY CONNECTIONS

The KFT Practitioner facilities well-being and community connection activities related to behavioral health, healthcare, and linkages to social supports.

Specific activities may include:

- parent advocacy, crisis intervention, case management, transportation, clinical and peer support services, employment and career services.

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MOVING ON AND AFTERCARE

The KFT Provider team collaboratively plans with the family and their support network for transitions; whether to a new unit or transitioning from the KFT program. The KFT Practitioner supports the family throughout transitions: both planned and unplanned.

PLANNED TRANSITIONS

The KFT Practitioner works with the family to establish a timeline for pre-transition discussions to ensure tasks are being completed and barriers are addressed.

Pre-transitions tasks includes:

ensuring the family is in possession of pertinent documents (legal, medical, identification); has made any needed medical appointments and has signed releases of information; and identified new unit/housing.

The KFT Provider team provides referrals to community resources as needed.

The KFT Provider team celebrates the family's success and transition out of KFT with a warm hand-off to community based support. The KFT Practitioner completes a discharge summary that is documented in the case file.

The KFT Provider team facilitates aftercare support to the family for 3 – 6 months post-transition to ensure family stability, assess the adjustment to reduction in KFT services, and provide referrals to community based resources, if needed.

Note: the KFT Provider team may provide aftercare support beyond 90 days at their discretion. The alignment of family needs and staff resources may impact the agency's capacity to extend aftercare support beyond 90 days.

UNPLANNED TRANSITIONS

The KFT Provider team will make every effort to support the family in transition planning and identifying necessary resources.

Attempts include but aren't limited to:

unannounced home visits, sending letters to all known addresses, connecting with members of the family's formal and informal support network and other activities to engage the family.

The KFT Provider team makes every attempt to inform the family of how they can assist with appeals, grievances and the overall transition process.

The KFT Provider team continues all attempts to reach the family regarding aftercare support until all efforts have been exhausted; the family's voucher is formally terminated or there is confirmation the family relocated and the 90 day aftercare timeline is exhausted.

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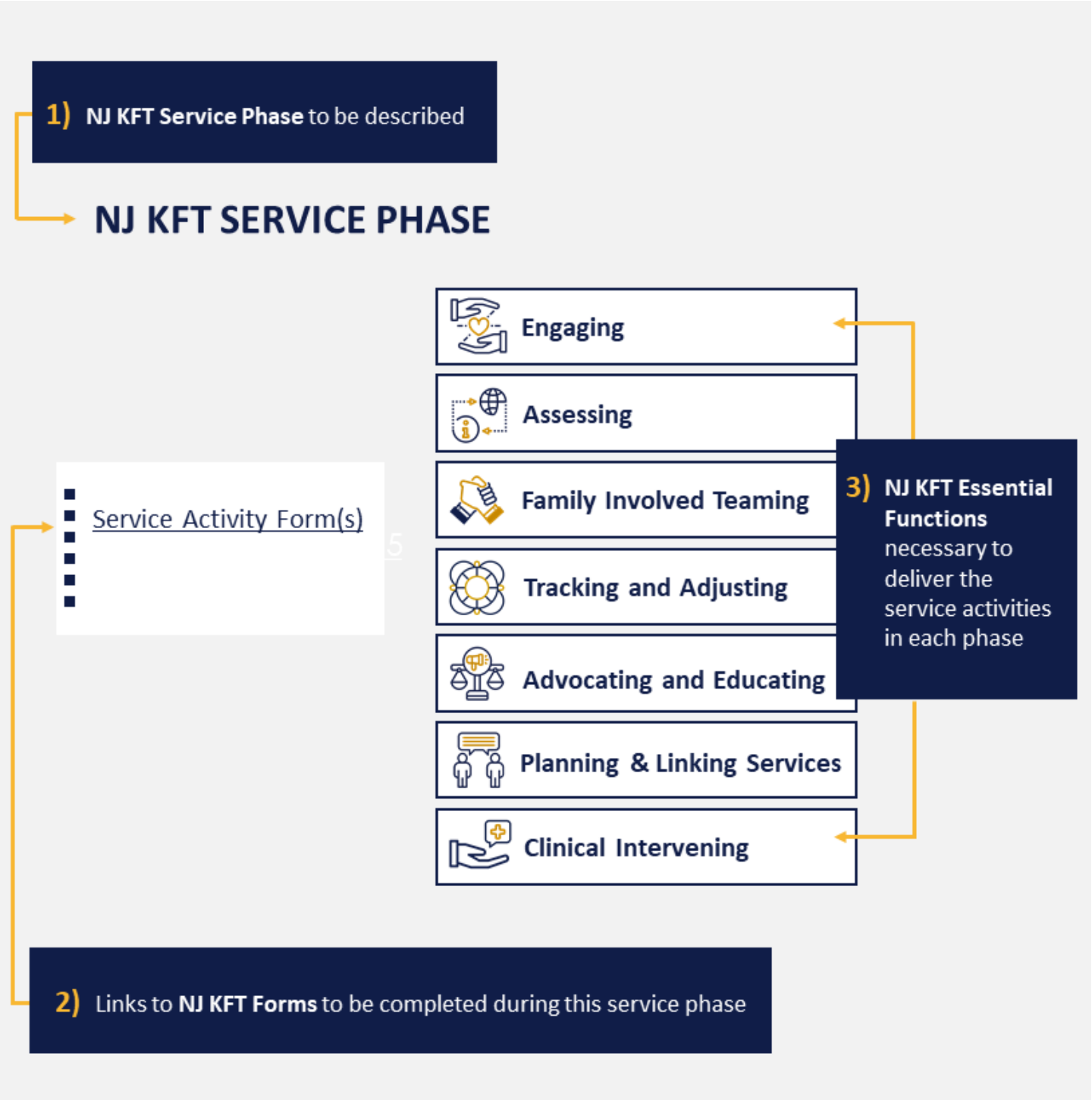
302 NJ KFT SERVICE DELIVERY

Each service phase described in this section includes a cover page outlining 1) a description of the **NJ KFT Service Phase**, 2) **NJ KFT Forms** required to be completed or administered during the indicated phase, and 3) the **NJ KFT Essential Functions** necessary to deliver the service activities in each phase.

For example:



303 PHASES OF THE MODEL

- **Referral and Pre-Enrollment**
- **Intake and Enrollment**
- **Stabilization and Maintenance**
- **Moving On and Aftercare**

Note, throughout this Section the terms NJ KFT team, NJ KFT Provider, and NJ KFT Practitioner are used frequently. The terms NJ KFT team and NJ KFT Provider are used interchangeably. NJ KFT Practitioner indicates the action is performed by a single NJ KFT staff person, and not the Provider team.

REFERRAL AND PRE-ENROLLMENT

SERVICE ACTIVITY FORMS:

- Housing Inspection
- Move-In Inspection
- Apartment Comparison Checklist
- Mainstream Resources Checklist
- Landlord Benefits checklist
- Monthly Budget
- Landlord Marketing Letter
- KFT Tips: Securing and Maintaining Housing

Engaging

Assessing

Family Involved Teaming

Advocating and Educating

304 REFERRAL AND PRE-ENROLLMENT

All families are referred to NJ KFT from the DCF's Division of Child Protection and Permanency (DCP&P). The referral process includes eligibility screening and pre-referral conferences initially completed by the NJ DCF KFT program lead, and subsequently the implementing Provider and the DCP&P team.

304.1 NJ KFT Eligibility Criteria

NJ KFT supportive housing services are designed for a subset of high needs DCP&P-involved families whose experiences with homelessness and/or housing instability have placed their children at risk of out-of-home placement or have delayed reunification with children currently in out-of-home placement. Families appropriate for NJ KFT also have co-occurring needs such as substance misuse, chronic medical and/or mental health needs and/or domestic violence risk factors.

NJ KFT eligible families must be DCP&P-involved (at the time of initial referral) and:

Meet at least **one** of the following DCP&P case goal criteria:

- Family Stabilization: One or more children at risk of out of home placement; **OR**
- Reunification: One or more children in out of home placement with a case goal of reunification; and Family deemed ready for reunification (indicators used to deem readiness may include: frequent, regular and high-quality parent-child visitation; completion and/or active participation in recommended services; safety issues resolved.) with housing as the only remaining barrier to reunification **OR**
- No established case goal: this includes circumstances where the case goal is still being established (for example, cases open with DCP&P investigation/intake team).

Meet at least **one** of the following homelessness and/or housing instability criteria:

- Family is sleeping on the street, in cars, or in other places not meant for human habitation
- Family has been homeless three or more times in the last 2 years
- Family is currently staying in a homeless shelter, transitional housing, or a residential treatment facility and will be homeless upon discharge
- Family has moved two or more times in the last 12 months
- Family is doubled-up living with family/friends because they are unable to find suitable housing
- Family is unstably housed and imminently losing housing within five to seven days (e.g., eviction, discharge from hospital/institution, living in condemned housing, etc.)

Meet at least **two** of the following risk factors/indicator of high service needs:

- Primary caregiver has current or recent documented substance use disorder
- Primary caregiver has mental health diagnosis/disorder
- Child has mental or behavioral health challenges
- Child has developmental, learning, or physical disability
- Primary caregiver and/or child has a chronic medical condition
- History of or ongoing domestic violence
- Age of youngest child is under six years old
- Primary caregiver has history of involvement with the child welfare system as a child/youth or other trauma history.

304.2 Pre-Referral/Initial Case Conference

The purpose of the pre-referral/initial case conference is to confirm the family's eligibility, discuss changes in the family's circumstances since the initial eligibility determination, facilitate sharing of case information between DCP&P and the Provider, and for the NJ KFT team to share information about program services and expectations. The NJ KFT team and DCP&P local office team completes this conference.

The case conference often occurs at the DCP&P local office and includes the following participants: DCP&P's local office NJ KFT liaison (this is often the Resource Development Specialist or RDS), DCP&P caseworker and supervisor along with the NJ KFT team (i.e., supervisor and practitioner).

During the case conference, participants discuss the family's eligibility including DCP&P case goal, housing status, and additional risk factors. The pre-referral/initial case conference may also include additional information regarding the status of household members as it relates to the following:

- Household income. If the family's gross annual income exceeds the maximum allowable (per DCA income guidelines), they may be deemed ineligible.
- Legal resident status. For certain NJ KFT voucher types, all household members must have legal status (i.e., KFTRAP). Since this criterion does not apply to all housing types, teams should aim to screen families in and not out. When in doubt teams should reference training material from the NJ KFT housing voucher training for more details and guidance.
- Criminal history and background checks, if applicable:
    - Note, for DCA vouchers, the following criminal history status are considered HUD exclusionary criteria. If applicable for any household member it makes the household ineligible for voucher assistance.
        - Household member is a registered (tier 3) sex offender.
        - Household member found guilty of cooking methamphetamines while on public housing property or involved with a public housing program.

Finally, the NJ KFT team reviews the scope of the program services with the DCP&P team. During this conference, the NJ KFT team also identifies whether DCP&P has available in the family's case files any of the required documents to support the housing voucher application.

304.3 Post Case Conference and Family Introduction

Once the initial case conference is complete and the family is deemed eligible, the DCP&P staff facilitates the initial introduction of the NJ KFT program to identified families, and inquiries about their interest in participating.

- If the family declines the NJ KFT program, DCP&P notifies the NJ KFT Provider and the team selects another family. The DCP&P team continues to support the family via community-based services and works in collaboration with the NJ KFT team to identify and connect the family with local housing resources.
- If the family expresses interest in NJ KFT, DCP&P staff works in collaboration with the NJ KFT team to schedule an intake and enrollment meeting with the family. Ahead of the meeting, DCP&P encourages the family to bring all available documents (e.g., birth certificates, social security cards etc.) to the enrollment meeting.

INTAKE AND ENROLLMENT

SERVICE ACTIVITY FORMS:

- Housing Inspection
- Move-In Inspection
- Apartment Comparison Checklist
- Mainstream Resources Checklist
- Landlord Benefits checklist
- Monthly Budget
- Landlord Marketing Letter
- KFT Tips: Securing and Maintaining Housing
- Voucher application
- Housing Preference Checklist
- Tenant Handbook
- HUD Tips: Searching for a Unit
- KFT Housing Flowchart
- HUD Lease-Up Process
- KFT Baseline Survey
- DCF Evaluation Consent

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305 INTAKE AND ENROLLMENT

The purpose of the enrollment meeting is to orient the parent to NJ KFT and plan for next steps with the family. The enrollment meeting should occur at a location that is convenient for the family (e.g., in the community, DCP&P office, etc.) and includes the family, DCP&P and NJ KFT team. DCP&P, who has an existing relationship with the family, takes the lead in the beginning of the discussion to introduce NJ KFT to the family. The NJ KFT team then welcomes the parent/family and answers any questions. During this Intake and enrollment discussion, the NJ KFT team introduces themselves and the program and explains NJ KFT services. The NJ KFT Practitioner allows the family time to tell their story and gather any information the parent(s) would like to share at that time. The NJ KFT team initiates necessary intake paperwork that may include confidentiality forms, biopsychosocial, HIPAA paperwork, agency forms, NJ KFT evaluation consent, etc.

The NJ KFT team should provide the family with an orientation to the program. This includes discussing:

- Program goals
- Services available
- Team members/Staffing
- Expectations (of both the Provider and Parent)

Finally, the NJ KFT team concludes the enrollment meeting by beginning a discussion about the housing voucher application and required documents (e.g., social security cards, birth certificates, bank statements, etc.), if the family is prepared to do so. The NJ KFT team also collects copies of supporting documents from the parent, if available during this discussion.[3]

305.1 Referral

Now that eligibility is confirmed and the family has indicated interest in participating, the DCP&P caseworker completes the NJ KFT referral packet and provides the information to the NJ KFT Provider. The NJ KFT referral packet includes the completed NJ KFT Referral Form and all supporting documents (for example the DCP&P Case Plan/Family Summary, prior evaluation reports, etc.). The DCP&P caseworker forwards the referral packet directly to the NJ KFT team electronically or by fax following the enrollment meeting with the family. Referrals should be sent to the identified NJ KFT staff during the Provider's operating hours.

Once a referral is received by the NJ KFT team, it is reviewed for accuracy and completion (i.e., all areas of the referral form are complete, the necessary supporting documents are attached, etc.). If the referral is incomplete, the NJ KFT team should communicate with the DCP&P team about any missing or incorrect information and explain the importance of receiving the information to support case planning and service implementation.

When the completed referral is received, the NJ KFT supervisor emails the DCP&P team to confirm receipt of the referral and next steps. Due to the nature of the intervention, NJ KFT does not maintain a formal waitlist. Upon receipt of the referral information the NJ KFT supervisor assigns the family to a NJ KFT Practitioner who will schedule follow up meetings with the parent moving forward.

[3] Note, this information is intended to be supplemental to the complete NJ KFT Housing Voucher Training. Additional information on NJ KFT trainings are provided in Section 400.

305.2 Pre-Tenancy Services (voucher application and housing navigation)

Pre-tenancy services refer to all activities completed by the NJ KFT team to help the family transition to the unit. This may include assistance with the housing application and unit search, identifying the parent's housing preferences, assistance with move-in expenses (i.e., security deposit), arranging for the actual move, and resolving other barriers to tenancy (Paradise & Ross, 2017).

The NJ KFT team supports families in pre-tenancy services to ensure housing is secured as quickly as possible. Once the referral information is confirmed the NJ KFT team works closely with the family to complete and submit the voucher application along with the required documents. Pre-tenancy services also include the critical work of gathering documentation, submitting the voucher application, and the housing search process to secure a unit. Let's take a close look at each of these components and the role of the NJ KFT Practitioner.

Gathering Documentation

After the intake and enrollment meeting, the NJ KFT Practitioner works in collaboration with the parent to complete the DCA voucher application and gather supporting documents. The NJ KFT Practitioner's discussion with the parent should include, but is not limited to, identifying the necessary forms and documents for submission to DCA and details about the documentation gathering process.

During planning discussions with the parent, the NJ KFT Practitioner discusses the following DCA **required forms**:[4]

- Voucher Application packet: DCA voucher application, tenant information form (TIF), Declaration of Citizenship, Megan's Law Registrant Form, Certification of Zero Income, Certification of Disability etc.
    - Note, the voucher application **MUST** include a contact from the NJ KFT team as an optional third-party person; this is to ensure critical notifications are received by the NJ KFT team throughout the application process.
- Supporting documents includes photo identification, social security cards, birth certificates, income verification (e.g., Benefit Awards letters from TANF GA, SSI, SSD, unemployment, child support statements, proof of earned income including pay stubs) and asset Verification (e.g., bank statement, pension statements etc.).

Important Notes about Gathering Documentation:

- Gathering documentation often requires extra time as families experiencing homelessness and housing instability may often misplace or lose identifying documents. All efforts should be made to expedite the process of gathering documents by working in partnership with State and local agencies (like the NJ DMV—the Division of Motor Vehicles) to secure items like photo identification.
- When gathering documents and sharing the family's personal information with DCA, *NJ KFT teams must **always** maintain confidentiality.*
- NJ KFT teams work in close collaboration with the parent (and other partners when applicable, for example DCP&P) until the voucher application is complete and all supporting documents are received.

[4] Note: Please review DCA's documentation list for full details on all required documents along with current applications and supplemental forms as these forms may change over time.

Submitting the Voucher Application

When the voucher application is complete, including supporting documents, the NJ KFT team (most often the NJ KFT supervisor) submits the completed application to DCA for review.

After the application is approved by DCA, the NJ KFT Practitioner works with the DCA field office, and the parent, to schedule the DCA voucher briefing meeting. The NJ KFT Practitioner should be notified of this meeting by the DCA field office staff. Of note, the briefing may occur in person or virtually. It is **MANDATORY** for the parent to be present at this meeting to receive the housing voucher.

The NJ KFT Practitioner attends the scheduled DCA briefing meeting, whether in-person or virtually. If the appointment is in person, NJ KFT staff may meet the parent at the DCA office or provide transportation for the parent, if needed. Since the parent may be asked to provide updated supporting documents during this meeting, (e.g., proof of income, awards letters, child support statements etc.) the NJ KFT Practitioner should be prepared with document copies, if available.

During the briefing meeting DCA staff reviews voucher rules and regulations, determines the unit size and explains unit costs to the parent. At the end of the briefing meeting, the parent signs the housing voucher and can begin the housing search process.

Housing Search and Securing the Unit

NJ KFT is supported by a mix of housing options that include both single and scattered-site units. Families in scattered-site units engage in housing searches to secure an affordable rental property that meets the family's needs. This process involves various partners and can often take a long time but is a key opportunity for relationship building between the NJ KFT Practitioner and the family. NJ KFT Practitioners may use the housing search process as an opportunity to (Ahsan, 2016):

- Help parents think about what they need for their family both in their home and in a community.
- Get to know all family members within the context of housing search visits.
- Model and coach families on engaging with landlords (including what questions to ask, roles and expectations.)

The NJ KFT Practitioner works with the parent throughout the housing search process to identify and select a housing unit (this includes contacting landlords, attending apartment viewings and other search activities, with the parent as necessary). NJ KFT Practitioners should provide transportation to support the search process, if needed. When supporting families in the housing search, NJ KFT Practitioners should note the following considerations:

- ***Background checks:*** The parent will likely be asked to complete background and credit checks by the landlord. Should the parent (or other household members) have previous evictions, criminal history and/or negative credit history that can interfere with approval for an apartment, the NJ KFT Practitioner (with the required written permissions) should advocate and negotiate with a landlord on the parent's behalf.
- ***Application fees:*** Most landlords (especially large apartment complexes) charge an application fee that pays for the completion of background checks. The NJ KFT team can provide financial assistance with application fees.

- ***Alignment of the parent/household's income with the cost of the unit:*** NJ KFT Practitioners should assist the parent with understanding the Fair Market Rent (FMR), income limitations, and making decisions about the affordability of an apartment. Of note, it is generally discouraged to make an agreement with landlords for rent that is above DCA's FMR for the family assigned voucher. Doing this increases the parent's risk of housing loss, especially if there is a change in income (the parent is responsible for the entire amount of rent, stated in the lease, that is over the FMR).
- ***The timeline to secure housing and extensions:*** The parent has 60 days from the voucher briefing meeting to secure housing, with the possibility of a 30-day extension. The NJ KFT Practitioner should work with the parent to secure housing within the identified timeframe. After identifying a unit, the parent and landlord must provide DCA required forms within the identified timeframes (e.g., submitting the Request for tenancy (RFT) form within 60 days). Upon written request to DCA, the voucher search process may be extended an additional 60 days if there is written justification of extenuating circumstances. If housing is not located within 120 days of receiving the voucher, the parent runs the risk of losing the housing voucher.

Finally, when a housing unit is secured, the NJ KFT Practitioner assists the parent in preparing for the unit's inspection by facilitating discussions about the process, timelines, and other considerations (e.g., the landlord must be present for the inspection and the parent's attendance is optional). Note, clear communication with the parent throughout this process is important to ensure notifications from DCA are not missed along the way as this may significantly delay the housing process.

Please see Section 500 and Appendices for forms and additional resources that support this section.

STABILIZATION AND MAINTENANCE

SERVICE ACTIVITY FORMS:

- Housing Inspection
- Move-In Inspection
- Apartment Comparison Checklist
- Mainstream Resources Checklist
- Landlord Benefits checklist
- Monthly Budget
- Landlord Marketing Letter
- KFT Tips: Securing and Maintaining Housing
- KFT Services Survey

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306 STABILIZATION AND MAINTENANCE

Now that the family is safely housed, the NJ KFT team provides a robust array of supportive in-home services that are tailored to meet the family's needs. While the continuum of post-tenancy services run the gamut from Stabilization and Maintenance through Aftercare, this section is focused on the Stabilization and Maintenance phase of the work.

In this phase of the work, NJ KFT Practitioners are tasked with supporting families in achieving identified goals. It is important to note that all NJ KFT services are voluntary for families, but not voluntary for the Provider team. This means parents do not need to be sober or "housing ready" to access NJ KFT services. Another consideration the NJ KFT Practitioner should note is, due to the long-term nature of the intervention, families often remain in the Stabilization and Maintenance phase for much of the time they are enrolled in NJ KFT.

Practitioners should keep in mind that NJ KFT supports families with high needs, who often have a history of connection with various service systems (e.g., child welfare, mental health, drug and alcohol treatment, judicial systems etc.). Families with prior experience within services systems may be hesitant to engage in services, for a variety of reasons including stigma and lack of trust. In addition, experiencing unstable housing and homelessness can make it difficult for families to form trusting relationships with safety net systems intended to provide support (e.g., education, health care, childcare, etc.). Considering these factors, NJ KFT parents may be less prepared to engage with NJ KFT teams, and other partners, as decision-makers and advocates for themselves and their children (Ahsan, 2016).

To bridge the gap between families and community services, link families to services, and sustain necessary social connections, NJ KFT Practitioners should understand the service considerations discussed here. For families, their relationship with the NJ KFT Practitioner helps to build the trust needed to nurture and sustain newly developed relationships within the larger community.

Since services are voluntary and family-driven, the intensity of service provision is determined by collaborative case planning processes with the family and supported by assessments. The ways NJ KFT Practitioners support families will vary based on the family's needs, goals, and readiness for change. NJ KFT Practitioners can expect to support various services goals at different times, at varying intensities. It is important for NJ KFT Practitioners to recognize providing services is not a linear process and progress will ebb and flow (Morrison & Samuels, 2016).

Throughout this process, NJ KFT Practitioners should sustain an emphasis on a culture of Moving On. This begins at the onset of NJ KFT involvement as practitioners help NJ KFT families to understand that one of the goals of the program is to help build skills to the point of no longer requiring the services offered and someday being able to move on from NJ KFT support services. It is in these first months of tenancy that NJ KFT Practitioners should complete the initial Moving On assessment to provide a baseline and initiate the conversation around goal planning.

Assessments and Case Planning

To support planning and service provision, NJ KFT teams facilitate an ongoing assessment process with the family. Below we have included a general overview of the Assessment and Case Planning process, please review the NJ KFT Practice Profile (Appendix C) for a detailed description.

NJ KFT Practitioners work in partnership with families to develop a service plan informed by the family's strengths, needs, and goals. Ideally, the process of building a service plan provides an opportunity for family members to enhance their protective and promotive factors by exercising critical skills like goal setting, problem-solving, sequential planning, etc. NJ KFT Practitioners utilize Motivational Interviewing (MI) to enhance the family's critical skills. By making decisions for, and not with families, we can unintentionally undercut parental resilience. When we do this, it sends the message that we do not trust their ability to make effective decisions and undermines their sense of self-efficacy. By placing family members in the center of the process of weighing options and choosing strategies, we help them to build and practice decision-making and advocacy skills that support ongoing resilience and capacity to access concrete supports. Again, this is informed by MI; which emphasizes supporting change in a way that fits with a person's own values and concerns. MI also understands that ambivalence is a normal part of the change process and actively explores with the families to guide them in making choices for their lives.

It is important for NJ KFT Practitioners to also ensure help is provided in a manner that does not increase stress. Services should be coordinated, respectful, caring and strength-based. Attention should be paid to the time and logistical requirements of participating in the proposed services. Too often for high needs families, service Providers focus on connecting them to an array of services without intentionally considering the challenges families face when trying to access multiple services.

In the end, how services are provided is as important as what is provided. NJ KFT Practitioners should collaborate with families throughout the life of the family's NJ KFT involvement. The family's needs and stability should govern the types and timing of referrals to partners and community resources.

An important aspect of delivering ongoing services and support is to continue to apply assessment skills in an ongoing way to understand what is happening in a family's life, changes that should be celebrated, or concerns that need to be addressed head-on.

Finally, the family's progress towards goals is reassessed at regular intervals[5] to determine the need for service adjustments. This involves periodic plan reviews where family members, including youth, and the NJ KFT Practitioner evaluates successes of service delivery and identify next steps. It also requires frequent and consistent communication with all team members, encouraging any team member to request a meeting at any time to help further the family's well-being.

[5] Refer to NJ KFT Practice profile for the time intervals of KFT's formal assessments.

306.1 NJ KFT Services

Families enrolled in NJ KFT have access to the following support services during the Stabilization and Maintenance as well as the Moving On and Aftercare phases of the model:

- Case management (Housing and Support Services)
- Clinical Services (Individual and Group)
- Concrete support (One-time financial support for security deposits, and other costs related to initial move in, along with limited transportation)
- Linkage to community-based services

Case Management (Housing and Support Services)

NJ KFT Practitioners provide case management support beginning at intake and enrollment and continuing throughout the entirety of the family's NJ KFT involvement. The practitioner leverages case management to support a range of activities aimed at maintaining housing stability and increasing well-being and family functioning while ensuring service provision is integrated (Arabo et al., 2016). A sample list of activities is listed below. Although it is not an exhaustive list, it is intended to serve as an example of commonly offered NJ KFT services that are supported through case management.

Commonly Offered NJ KFT Support Services	
Housing Stability	**Well-Being and Community Connections**
• Housing needs assessment and neighborhood preferences • Housing application and voucher maintenance (Recertification etc.) • Development of housing plan • Housing search • Landlord engagement • Security deposits • Eviction prevention • Obtaining furniture and other household items • Service coordination (Arabo et al., 2016)	• Needs assessment and intensive case planning • Crisis services • Peer support services • Non-emergency transportation • Individual and group therapy • Navigation–i.e., accompanying parents to appointments • Service coordination • Linkage to additional supports: • Employment, education, nutrition, legal services, budgeting and finances, benefits coordination (i.e., food stamps, health insurance), access to child-care, etc. (Arabo et al., 2016)

Clinical Services (Individual and Group)

Below we've included a general overview of the Clinical Services, please see the NJ KFT Practice Profile (Appendix C) for a detailed description of Clinical Intervening.

NJ KFT clinical services are provided by licensed clinicians and designed to support families in meeting their clinical needs. These services are available on both the individual and family level, as needed; with varying frequency based on the identified needs, goals, and readiness for change.

When considering housing as a platform from which families meet their other needs, NJ KFT Clinicians must intentionally consider the relationship between housing stability and the family's mental wellness. Additionally, clinical interventions must align with the family strengths, needs and cultural context to ensure effectiveness.

The NJ KFT Clinician should be aware of the stressors (at varying levels -individual, community, etc.) with which many families are coping. They must also consider that many families have been, and continue to be, exposed to a range of traumatic experiences, for example, community violence, domestic violence, physical abuse, and complex grief.

Finally, when supporting families with clinical needs that extend beyond the scope of NJ KFT services the clinician should link the family to the appropriate level of clinical care within the community (e.g., partial day treatment, psychiatric monitoring etc.).

Concrete Support

It is no surprise that providing help when families need it can help avert crises that contribute to instability. The NJ KFT intervention by nature is very attuned to the provision of concrete supports to families (Ahsan, 2016). The NJ KFT Practitioner's role is to assist parents with identifying, navigating, and securing concrete supports that meet basic (e.g., food, safe housing, transportation, etc.) and specialized needs (e.g., medical, mental health, social, educational, or legal services).

Families enrolled in NJ KFT have access to the following concrete services:

- Funds to support one-time expenses. This may include costs related to securing and/or maintaining housing (i.e., security deposit, application fees etc.) and
- Non-emergency transportation (this is available on a limited, as needed basis)

A sample list of concrete support services is listed below. Though not an exhaustive list, it is intended to serve as an example of commonly offered concrete support services available through NJ KFT. ***Of note***, NJ KFT funds to support one-time expenses must be approved by DCF and utilized as a last resort after all other resources have been explored and/or exhausted.

Commonly Offered NJ KFT Concrete Supports	
Housing Stability	**Well-Being and Community Connections**
• Rental applications • Landlord engagement costs (i.e., incentives, etc.)	• Household items (i.e., furniture, linens, child-proofing items etc.) • Employment related costs (i.e., licensing fees) • Driver's license related costs • Education related costs (i.e., school uniforms, books etc.)

Linkage to Community-Based Services

NJ KFT teams work to ensure that families' unique needs are met and that they have access to a wide range of supportive services. There are instances where the needs of families must be met within the community. In these instances, the NJ KFT Practitioner connects families to community-based resources best suited to meet the identified needs.

A sample list of common service linkages is listed below. Though not an exhaustive list, it is intended to serve as an example of the most common referrals/linkage to community-based services that NJ KFT teams facilitate.

Common NJ KFT Service Referral and Linkages	
Housing Stability	**Well-Being and Community Connections**
• Legal Services (i.e., eviction prevention)	• School based services (i.e., Early Intervention (EIP), IEP etc.) • Domestic violence support (i.e., shelter/safe house, etc.) • Health Insurance and Medical Care (i.e., Primary Care and specialized services) • Entitlement Programs (TANF, SSI, WIC, etc.) • Mental Health (i.e., psychiatric care, outpatient services, partial/residential care etc.) • Substance use treatment services • Childcare • Financial planning and credit repair • Faith-based support • Other community wellness programs

Please refer to Section 500—Forms and Appendix section for additional resources that support this section such as the Tenant Handbook (located in Forms).

MOVING ON AND AFTERCARE

SERVICE ACTIVITY FORMS:

- Housing Inspection
- Move-In Inspection
- Apartment Comparison Checklist
- Mainstream Resources Checklist
- Landlord Benefits checklist
- Monthly Budget
- Landlord Marketing Letter
- KFT Tips: Securing and Maintaining Housing
- KFT Services Survey

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307 MOVING ON AND AFTERCARE

Moving On from NJ KFT is the process of supporting families who no longer require NJ KFT services to transition to private units (with, or without, rental support) and less intensive community-based support. This allows for newly vacant units to be made available for families most in need of NJ KFT. The goal of Moving On is to promote the highest levels of independence and choice for parents. NJ KFT Practitioners should not consider Moving On a singular stand-alone activity, since it also refers to a way of work that empowers families to take steps forward and provide them with the supports necessary to live in the housing of their choice. As stated above, this work begins at the onset of NJ KFT involvement and should permeate the working relationship between NJ KFT Practitioner and NJ KFT families.

It's important to note, Moving On impacts housing and homelessness on multiple levels.

- At the individual level, it promotes higher levels of independence by giving parents the opportunity and choice to make the transition to less intensive service environments.
- At the systems level, Moving On efforts address some of the pressure related to the availability and capacity of supportive housing by making available supportive housing units for vulnerable families facing homelessness and/or housing instability.

While estimates vary, an approximate three to ten percent of NJ KFT families in any given year may be ready to move on.[6] This variation depends on multiple factors including but not limited too; family needs, the general housing market and the degree to which NJ KFT teams embrace an ongoing Moving On strategy and intentionally promote a culture that maximizes family independence.[6]

NJ KFT Practitioners should begin Move On discussions with the family at the onset of NJ KFT involvement. The formal process of assessing Move On readiness should be completed in an ongoing way in collaboration with the family and their support team. At minimum, the NJ KFT Practitioner should assess Move On readiness every six months. This may coincide with naturally occurring transitions, such as lease renewals or voucher recertification.

The following information is intended to be supplemental to the comprehensive NJ KFT Training on Moving On. Additional information on NJ KFT trainings are provided in Section 400.

307.1 Assessing for Moving On Readiness

The most crucial determinant of a family's readiness to move on is the family's voluntary desire to do so. Ongoing assessment helps families and Practitioners better define that readiness and needs beyond the support of the family. Executed properly, the assessment process can help to focus both family and practitioner on goals and action steps to help families move on when they desire to do so.

NJ KFT utilizes various assessment tools (e.g., the Arizona Self Sufficiency Matrix and the Supportive Housing Acuity Index) to identify families who are ready to Move On. While standardized assessments are critical tools to help evaluate family needs, strengths, and functioning, they should not be the only means of assessing Move On readiness. These quantitative assessment tools should be complimented by in-depth, qualitative methods (e.g., family teaming with formal and informal supports like DCP&P etc.) that provide a well-rounded view of the family's motivation, confidence, and emotional readiness to Move On.

[6] For more inforation, please refer to CSH's Moving On Toolkit available here: https://www.csh.org/resources/csh-moving-on-toolkit/

When assessing families for Move On readiness, the NJ KFT Practitioner should consider the following elements in collaboration with those identified during the standardized assessment process; finances (employment supports and connection to benefits like TANF), daily living skills, identifying housing supports, community living skills and connections to community-based services (e.g., schools).

Finances

One of the primary reasons for losing housing, after moving on from supportive housing, is non-payment of rent. While NJ KFT Practitioners should work with parents to develop a budget prior to transitioning, there are often unforeseen costs realized after moving out and maintaining a budget may be more difficult than anticipated for some parents. New landlords may not allow the same kind of leniency and flexibility that parents have become accustomed to while in NJ KFT (e.g., late rent payments and fees); parents may need support in adapting to these new standards. When choosing a new unit, it is critical to ensure that parents are not facing excessive rent burdens (e.g., keeping rents to no more than 30% of total income) and have a minimal level of savings or a reliable flow of income. This serves as a buffer to ensure a single crisis doesn't result in a return to homelessness. NJ KFT Practitioners should monitor parents' ability to maintain their budgets and avoid rental arrears, utilities, or other debts and provide support during their first few months in their new home. When needed, practitioners should offer financial skill-building or linkage to organizations that can provide this. NJ KFT Practitioners should also work with parents in managing immediate financial considerations associated with moving. This includes reviewing and planning with the parent a moving budget that accounts for the following: rental application, background/credit checks, other processing fees, security deposits, moving truck, outstanding utility balances, etc. NJ KFT Practitioners work with the family's formal and informal supports to meet these immediate moving costs; this may also include support from NJ KFT.

Daily Living Skills

Parents who've relied on NJ KFT Practitioners to assist with many of their daily living skills may need significant support during the initial transition period. While NJ KFT practitioners should work with parents to practice these skills before the move, they should also ensure parents can perform these skills independently in their new setting. In addition to daily living skills (e.g., cooking, shopping, cleaning, accessing public transportation), NJ KFT Practitioners should monitor parents' abilities to perform critical activities that impact their health and safety, correctly dosing/taking medications, attending health appointments, understand safety and emergency protocols (fire evacuation procedures, how to call for help, accessing/operating fire extinguishers) and managing mental health symptoms or relapse triggers.

Of note, NJ KFT Clinicians should include the following additional considerations: clinical assessment regarding the impact of the move on the family's mental health or recovery, the availability/accessibility of therapeutic services and the plan for transferring clinical support. Additionally, this can be a focus of non-clinical staff as well since they monitor for changes in behavior with families who are preparing to move on. It is not uncommon for families or any individual to experience these feelings. Those team members that interact with the families most closely may be best suited to notice signs and inform clinicians of observed behaviors.

Identifying Housing/Rent Supports

Affordability is a primary barrier that often prevents current supportive housing families, who no longer need services, from moving on. Some NJ KFT families are employed in jobs that are intermittent, pay low wages or are on fixed incomes (often SSI/SSD). With this in mind, NJ KFT Practitioners must collaborate with local housing partners (i.e., DCA, Public Housing Authorities (PHAs), Affordable Housing Property Owners, and/or other State and Local subsidies) to support the identification of housing and rent supports that best align with family's needs and income.

Community Living Skills and Connections to Community-Based Services

Ensuring continuity of services for families throughout the transition is crucial. The NJ KFT Practitioner should begin connecting the family to new community-based Providers well in advance of the move and facilitate "warm hand-offs". NJ KFT Practitioners should observe parents' ability to independently manage their new relationships and provide any coaching or additional support, as necessary.

307.2 The Moving On Process

Moving On and transition planning with families are typically expected and planned. There may be instances when unplanned transitions occur for various reasons. In both scenarios, the NJ KFT Practitioner's role is to support the family throughout the Moving On process.

Below are considerations for ways the practitioner should support families when moving on from NJ KFT in both planned and unplanned transitions, in addition to suggested timelines for transition activities.

Planned—Move On and Transition Planning

NJ KFT Practitioners must include the following considerations when supporting families through a planned transition from NJ KFT:

- Current lease status,
- Plan for notifying the landlord and DCA of the move,
- Potential changes in unit size and rental cost,
- Potential barriers (e.g., credit history, criminal background, landlord references),
- Informal supports, and their role in the transition
- Transportation access
- Coordination with other partners supporting the family (including DCP&P and other agencies)

Note, the suggested timeframes below are estimates and not uniquely tailored to each family. The NJ KFT Practitioner should adjust timeframes to best align with the family's needs. For example, if a parent requires additional support with securing documentation the NJ KFT Practitioner should begin this process earlier than indicated below (i.e., one month before transition).

Suggested Timeline for Planned—Move On and Transitions[7]

Time Frame	Task
Three months before transition	The planning process begins with a collaborative (parent & NJ KFT Practitioner) review of the most current assessment (or completing a new one if it is not timely) to identify areas that will require immediate action or the need for continued supports. Post NJ KFT/ Aftercare information should be reviewed with the parent to ensure they are aware of the post NJ KFT process and implications of transitioning.
Two to three months before transition	A timeline is collaboratively established for check-ins between parent and NJ KFT Practitioner to ensure pre-transition tasks are completed. Notify the landlord and/or DCA of the planned move.
Two to three months before transition	The NJ KFT Practitioner supports the family in making connections with formal and informal supports who have been identified as resources for continuing support.
One month before transition	The NJ KFT Practitioner works with the parent to ensure possession of documentation, including legal, medical, identification, or other needed documents. The parent is supported in making any needed medical appointments. The NJ KFT Practitioner works with the parent to update releases of information and other forms, as needed.
At transition date; no later than 30 days post-transition	The NJ KFT Practitioner completes the transition/discharge summary; the summary is filed in the parent's inactive chart. With the parent's permission, the transition/discharge summary is forwarded to any appropriate person/agency to promote continuity of support services.
Three to six months post-transition	The NJ KFT Practitioner makes at least three attempts (at least one per month for the first three months) to follow-up with the family to determine status and need for post NJ KFT support.

[7] Suggested timeframes are generalized and not uniquely tailored to each family. The NJ KFT practitioner should adjust timeframes to best align with the family's needs. For example, if a parent requires additional support with documentation the NJ KFT practitioner should begin this process earlier than indicated.

Unplanned—Move On and Transition Planning

While most families move on from NJ KFT through planned and intentional collaboration, there are circumstances where families move on unplanned or abruptly for various reasons. Families may move on unplanned due to evictions, DCP&P case goal changes, abandonment of the unit, etc. NJ KFT Practitioners should make all possible effort to support the parent through an unplanned transition, including, but not limited to, the following considerations:

- Connect families to community-based resources (e.g., local housing resource, entitlement benefits etc.) and/or informal supports
- Ensure the family understands the implications of the unplanned transition on their housing status (e.g., for example, if the parent abandons the unit, how does this impact their rent subsidy etc.)
- Notify and explain to the family any appeal or grievance procedures

Suggested Timeline for Unplanned—Move On and Transitions[8]

Time Frame	Task
When indications of an unplanned discharge are observed ***or*** at the time of an abrupt transition	The planning process begins with a collaborative (parent & NJ KFT Practitioner) review of the most current assessment (or completing a new one if it is not timely) to identify areas that will require immediate action or the need for continued supports. If the parent cannot be located, the NJ KFT Practitioner should complete this task independent of the parent; *as best they can*.
At the time of the unplanned transition ***or*** within one-week post-transition	When issues that need continued attention are identified and the parent's whereabouts are unknown, the NJ KFT Practitioner should develop a list of external supports that may be utilized should the parent resurface. If the parent's whereabouts are ***known*** (incarceration, hospital, etc.) the list of possible external supports should be communicated to the agency now serving the parent.
Within the first two weeks post-transition	If the agency held any original documentation regarding the family's legal, medical, or education status or any original identification documents; attempts should be made to get these documents to the parent/family. If the parent's whereabouts are ***known***, appropriate releases of information should be completed so the documents can be forwarded to the agency now serving the parent.

[8] CSH and Connecticut Supportive Housing discharge Guidance document.

Suggested Timeline for Unplanned—Move On and Transitions Continued

Time Frame	Task
No later than 30 days post-transition	Complete the transition/discharge summary and file in the parent's inactive chart. With the parent's permission, forward the transition/discharge summary to any appropriate person/agency to promote continuity of support services.
Within the three months post-transition	Make at least three attempts (at least one per month for the first three months) to follow-up with the family to determine status and need for post NJ KFT support.

307.3 Aftercare and Post NJ KFT Support

Moving On from intensive services can be a significant life change for most families. While exciting, this time can also be highly stressful—especially during the first few months after moving on from NJ KFT. To support the family's successful transition from NJ KFT and adjustment to their new environment, the NJ KFT Practitioner continues to offer services and supports to families for a limited amount of time as needed after the move.

Post-NJ KFT services are typically provided for three to six months after families move on from NJ KFT; the length of time depends on the family's needs and the provider's capacity to facilitate services. Some families may need more frequent, longer support, and others may need minimal supports. When planning for transitions, NJ KFT Practitioners should consider the family's individualized transition needs. Please review the Moving On section above for suggested activities and timelines for planned and unplanned transitions.

Despite the preparation work with families, some may be surprised by the diminishing support and other changes they experience initially after moving. During aftercare, families are often balancing several adjustments in housing, community resources, local supports, and medical and behavioral health care providers. NJ KFT Practitioners need to be alert to the transition process, anticipate concerns, and be prepared to help families manage their emotions and fears to avoid falling into crisis. To mitigate the risk of crisis, NJ KFT Practitioners should include aftercare planning as part of their moving on discussions with parents.

Additional NJ KFT Activities

To support quality implementation of the NJ KFT model, NJ KFT teams also facilitate *System Collaboration* activities with various stakeholder partners. Below we have included a brief description of these efforts, with additional details for key partnerships.

308 COLLABORATION WITH KEY STAKEHOLDER PARTNERS

The needs of vulnerable families cannot be met by one public service system. NJ KFT teams must consider the holistic needs of families and collaborate with families themselves, as well as multiple services, professionals, and systems to knit together services that are flexible and responsive. Providers with established partnerships and experience working collaboratively to serve families are well-positioned to take on the NJ KFT approach. Stakeholder collaborations must have a shared focus on family success across all partners. As such, planful collaboration is an important activity for NJ KFT teams when working with other stakeholder partners to support families.

The following are considerations for working with various stakeholder partners to implement NJ KFT. While not intended to be an exhaustive list, the highlighted partnerships included below are considered central to supporting family success.

308.1 Families

Family representation is critical to defining the NJ KFT story. The voices and stories of families with lived experiences should be heard, highlighted, and used to inform the delivery of NJ KFT services. NJ KFT teams should be prepared to support families who share their stories by being planful in supporting them through the process, respecting boundaries, providing compensation, and ensuring emotional support is readily available when appropriate.

NJ KFT teams establish fully collaborative partnerships with families that encourage growth towards independence by both recognizing family strengths and resources and addressing jointly identified needs and priorities. Partnerships with families should be authentic and must include shared power and decision-making. When collaborating with families, NJ KFT teams must frequently check in to ensure a clear understanding of family experiences within the program.

Since families are often involved in multiple systems (child welfare, juvenile justice, or criminal justice system etc.)—whether voluntarily or involuntarily—NJ KFT teams should understand these systems to best support families. When partnering with families to navigate various systems, NJ KFT Providers should keep in mind competing mandates and timelines that need to be aligned with the family's identified goals.

308.2 State Departments and Agencies (NJ DCA and Other Departments)

NJ KFT programs are expected to work collaboratively with State and Local agencies to facilitate housing and support services for families. Other State and Local agency partners may include, but are not limited to, the Department of Community Affairs (DCA), Division of Family Development (DFD), County Board of Social Services, local Law Enforcement, to name a few. To best support families, NJ KFT Providers should understand the systems families navigate to meet their needs. For example, NJ KFT Providers must be familiar with DCA's voucher requirements, and work in concert with DCA field offices, to successfully house and sustain the family's housing.

308.3 Landlords and Housing Developers

NJ KFT Providers work collaboratively and communicate regularly with housing-related stakeholders such as property owners and landlords. The goal of this partnership is to address potential and/or current issues, to ensure families maintain stability and maximize tenure in their living arrangement. NJ KFT teams work with families and landlords to help problem-solve, remove barriers, and maintain housing stability.

Finally, working in partnership with landlords, housing developers, and other housing partners, allows NJ KFT teams to build trusting relationships that support flexibility and understanding; particularly when decisions are at the housing partner's discretion.

308.4 Community Partners

NJ KFT Providers demonstrate partnership and develop collaborative relationships with local services systems and provider networks to effectively advocate for and access resources/supports for families. It is important for NJ KFT programs to establish themselves as part of the community's response to meeting the needs of children and families. Attending meetings and consciously reaching out to build relationships in the community are an important investment.

NJ KFT teams must ensure that families are connected to community services as early as families are ready; and continue nurturing those connections that support long-term self-sufficiency and independence. NJ KFT teams also work in partnership with local service systems and provider networks to effectively advocate for and access much needed community resources and supports for families such as substance use disorder treatment and recovery supports.

Families benefit long term from being connected to community support groups, educational and vocational support, faith-based organizations, and other formal and informal supports and services.

308.5 DCP&P

Important note, when partnering with families involved with the child welfare system, providers should strive to work in partnership with the child welfare team to reduce the risk of harm to a child or youth, even while supporting the family from a very different role.

Collaboration between child welfare agencies and housing providers ultimately benefit the families served. Studies have shown that providing housing-related services can significantly reduce repeat maltreatment and facilitate reunification for families with children in foster care—even those for whom housing was not the reason for child welfare involvement (Dworsky, 2014).

DCP&P serves as the only referral source for NJ KFT. With this in mind, NJ KFT Providers have an important role in ensuring that DCP&P is well informed about program services, partnership expectations, and other relevant information to support the shared goal of the partnership. Developing a shared understanding and clear communication also ensures families receive clear and accurate information from both teams.

NJ KFT and DCP&P must work collaboratively and communicate regularly to ensure the safety, permanency, and well-being of the child(ren) and overall family success. While it is anticipated that a family's case will not close immediately upon program enrollment, the DCP&P case does not need to remain open for families to continue participation in NJ KFT. Safe and stable housing, coupled with support, often creates the environment for a family's DCP&P case to be closed.

When working in collaboration with DCP&P, the circumstance of reporting a family to child welfare may pose a challenge for practitioners. The goals of the child welfare system are to keep children safe, to stabilize families and to strengthen their ability to support themselves and their children. To best support families, NJ KFT

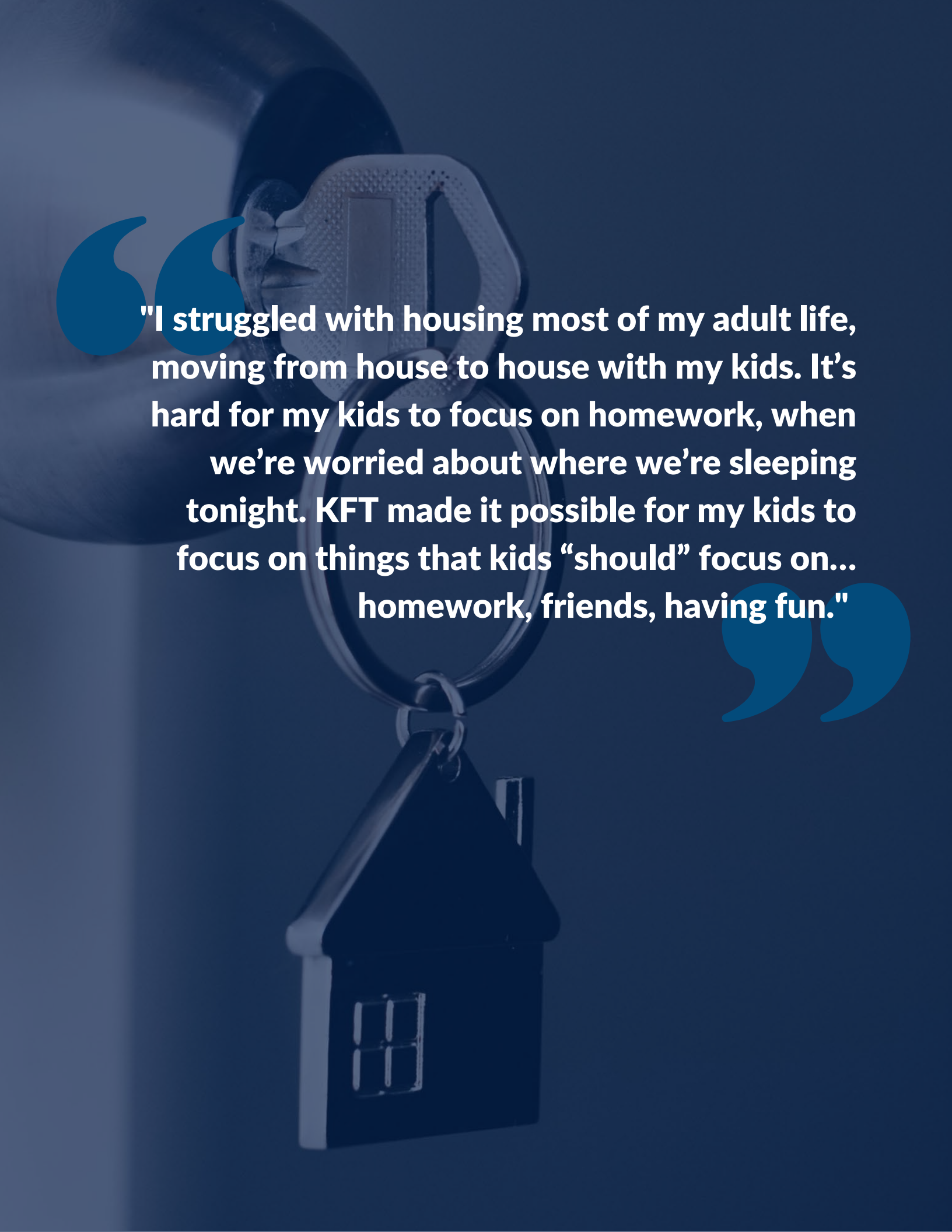
Providers should equip staff with information, in advance, about NJ's mandated reporting laws. Providers implementing NJ KFT must have clear internal processes about how to address safety and risk issues, when and how to report concerns to either law enforcement or child protection, and how to include family members in the process of making a report, if possible.

308.6 NJ KFT and Family Meetings

With the family's permission, NJ KFT Providers also participate in DCP&P—led family meetings to support the family's progress. Family meetings are generally held every three months and are facilitated by DCP&P staff with families to build a team of functional supports that will assist the family in achieving their goals. Teaming is the process in which DCP&P and families plan together regarding the case circumstances to move the family towards permanency goals and attend to service needs. Attendees of family meetings are determined by families and consist of formal supports (i.e., NJ KFT and other service providers) and informal supports (i.e., friends, family, resource parents, and other individuals from the family's identified network of support).

Finally, ongoing collaboration with DCP&P also includes:

- Joint case conferencing—While the family's NJ KFT case is open, the team participates in ongoing case conferences with DCP&P to support the family in coordinating services and resources. The frequency will vary as needed, but contact should occur at minimum monthly or more often, as indicated. Conferencing is especially critical to supporting NJ KFT families working towards reunification or families in crisis.
- Phone calls—the frequency will vary as needed, but contact should occur at minimum monthly or more often, as indicated.
- Written collateral reports: These are letters describing the family's progress. For NJ KFT families with an open DCP&P litigation case, a written collateral report should be shared with the DCP&P team to support court hearings at minimum every three months or at the request of the DCP&P team.



"I struggled with housing most of my adult life, moving from house to house with my kids. It's hard for my kids to focus on homework, when we're worried about where we're sleeping tonight. KFT made it possible for my kids to focus on things that kids "should" focus on... homework, friends, having fun."

SECTION 400

NJ KFT ADMINISTRATIVE OPERATIONS

FAMILY STORY

"...mom was successfully reunified with her daughter, who is disabled, and remains positive and hopeful as she works toward stabilizing in her new home with new responsibilities."

Mom called us (NJ KFT Provider) following her intake appointment, stating she was dropped off at a local Wawa, with a dying phone, nowhere to stay, and no money. NJ KFT staff picked her up from Wawa in tears; mom was homeless, struggling with mental health issues, off her prescribed medications, and in substance use recovery. Mom stayed in the NJ KFT office while we developed an interim housing plan; since she was not yet approved for a voucher. NJ KFT temporarily secured housing for the family at a local hotel, then later at a mental health respite for individuals in crisis. Community partners worked in collaboration with NJ KFT to keep the family in interim housing long beyond their typical stay, while the family waited for the voucher to be approved and permanent housing to be obtained. In the meantime, mom was stabilized on medication and had access to immense support from the NJ KFT team and community partners. Now, **mom has her own apartment for the first time in her life**. Mom expressed she has never felt more stable in her mental health, adding that she feels more confident in her sobriety today than she has in many years. Seeing mom now in comparison to the day we picked her up from Wawa is like night and day. Mom has a positive attitude, is motivated to succeed and has set goals to be a peer counselor to "give back" and help those who are going through similar situations to her. Additionally, mom was successfully reunified with her daughter and remains positive and hopeful as she works toward stabilizing in her new home with new responsibilities.

400
NJ KFT ADMINISTRATIVE OPERATIONS

401 NJ KFT STAFFING

The primary role of NJ KFT staff is to:

- Establish a trusting relationship with families to promote child well-being and family stability, while increasing the capacity of caregivers to provide a safe and permanent home for their children.
- Work with families to devise and implement a comprehensive, family-based service plan that focuses on child safety, positive family functioning and wellness and includes housing as well as other services needed by the family.
- Ensure housing retention and improve housing stability among families for ongoing family stability.
- Build a network of support within the program and among tenants that focuses on trust, well-being and social/community integration.
- Advocate on behalf of parents and children to ensure they understand the requirements of the social services in which they are engaged and facilitate access to public benefits available to them.
- Act as a liaison between parent and service provider(s) when necessary while building the capacity of the caregiver and child to communicate effectively and advocate for themselves.
- Motivate clients to seek licensed substance use disorder treatment and/or participate in recovery supports, as appropriate.

402 NJ KFT JOB DESCRIPTIONS

To support the provision of NJ KFT services, both direct and indirect staff positions are needed:

- Direct service roles include NJ KFT Practitioners (Housing Specialists and Employment Specialists) and NJ KFT Clinicians.
- Indirect service roles include NJ KFT Program Managers (Supervisors, Managers, or Program Directors).

The staffing structure must include core NJ KFT staff roles as indicated (including at minimum a NJ KFT Practitioner, NJ KFT Clinician, and NJ KFT Program Manager) to implement NJ KFT services as intended. When selecting staff, providers must identify individuals with the credentials and/or competencies to serve families facing a range of co-occurring challenges, including but not limited to substance use disorders, mental health, domestic violence, and trauma histories. Peers may also be built into an agency's NJ KFT staffing structure.

Listed below is a brief description for each of the staff roles. Job descriptions for NJ KFT positions align with the NJ KFT Practice Profile's Guiding Principles and Essential Functions. NJ KFT Providers should use these job descriptions for recruitment, selection, and hiring processes and modify these position descriptions as applicable to meet agency's requirements and/or staffing needs.

402.1 NJ KFT Practitioner

The NJ KFT Practitioner is responsible for providing guidance, extensive support, and resources to NJ KFT families. This role includes "hands-on" intensive case management support and includes the provision of the following services: conducting standard assessments, home visits, support throughout the housing process (including pre-application, housing search/navigation and ongoing tenancy support), linkage to community resources, facilitate the provision of concrete services (this may include administering NJ KFT specific assistance to clients funding, providing transportation, etc.), and serve as a liaison between the family and formal supports (e.g., DCP&P and other entities). The title NJ KFT Practitioner may also include roles such as: housing specialist, employment specialist, peer specialist, etc.

Job description for NJ KFT Practitioner can be found in Appendix E.

402.2 NJ KFT Clinician

The NJ KFT Clinician provides in-home therapy services for NJ KFT families; this may include individual and family therapy as needed. NJ KFT Clinicians support families in identifying treatment goals and providing therapeutic intervention aligned with meeting the identified needs (e.g., mental health, substance use, etc.).

Job description for NJ KFT Clinician can be found in Appendix F.

402.3 NJ KFT Program Manager

The NJ KFT Program Manager is responsible for the overall daily operation and implementation of the NJ KFT program. This may include recruiting, hiring/selection, coaching, supervising, data collection and reporting, participating in CQI activities, and delivering presentations. The NJ KFT Program Managers are also responsible for providing, or coordinating, clinical oversight for appropriate staff.

Job description for NJ KFT Program Manager can be found in Appendix G.

402.4 NJ KFT Champions

In addition to the positions listed above, NJ KFT programs also include the role of NJ KFT Champion. NJ KFT Champions serve as NJ KFT practice experts. They are charged with developing awareness of and improving staff's knowledge, skills, and competencies in the NJ KFT Practice Model through individual and group coaching. NJ KFT Champions receive additional NJ KFT coaching training and participate in ongoing learning collaboratives for support in NJ KFT coaching practices. Please refer to the NJ KFT Training and NJ KFT Coaching sections for additional information.

402.5 Additional staff, as needed

Additional staff, such as peer support specialists, may also be built into an agency's NJ KFT staffing structure.

403 NJ KFT INTERVIEW PROTOCOL

A key factor in NJ KFT success is the development of a NJ KFT staffing team to support vulnerable families. Ensuring the safety, stability, and well-being of vulnerable children and families is complicated, requiring a wide range of information and practice knowledge. One worker practicing alone with an individual caseload cannot know and do everything that needs to be done. It is recommended that Providers utilize an interdisciplinary team as outlined above. The team is a source for information, understanding, consultation, joint practice, and accountability. Each member of the team should bring identified skills outlined in the position descriptions as well as life experiences and perspectives.

Significant efforts should be made by NJ KFT programs to hire staff from within the communities being served and whose race, ethnicity and/or language reflect the families being served. NJ KFT staff must be viewed by families as a source of support and assistance for routine services and in moments of crisis. Staff must adopt a "whatever it takes" approach to be seen as a true source of support for families. Additionally, staff must be prepared to work beyond the purview of an ordinary nine-five workday, providing a wide range of assistance and "troubleshooting" around issues not typically viewed as part of the general social services system.

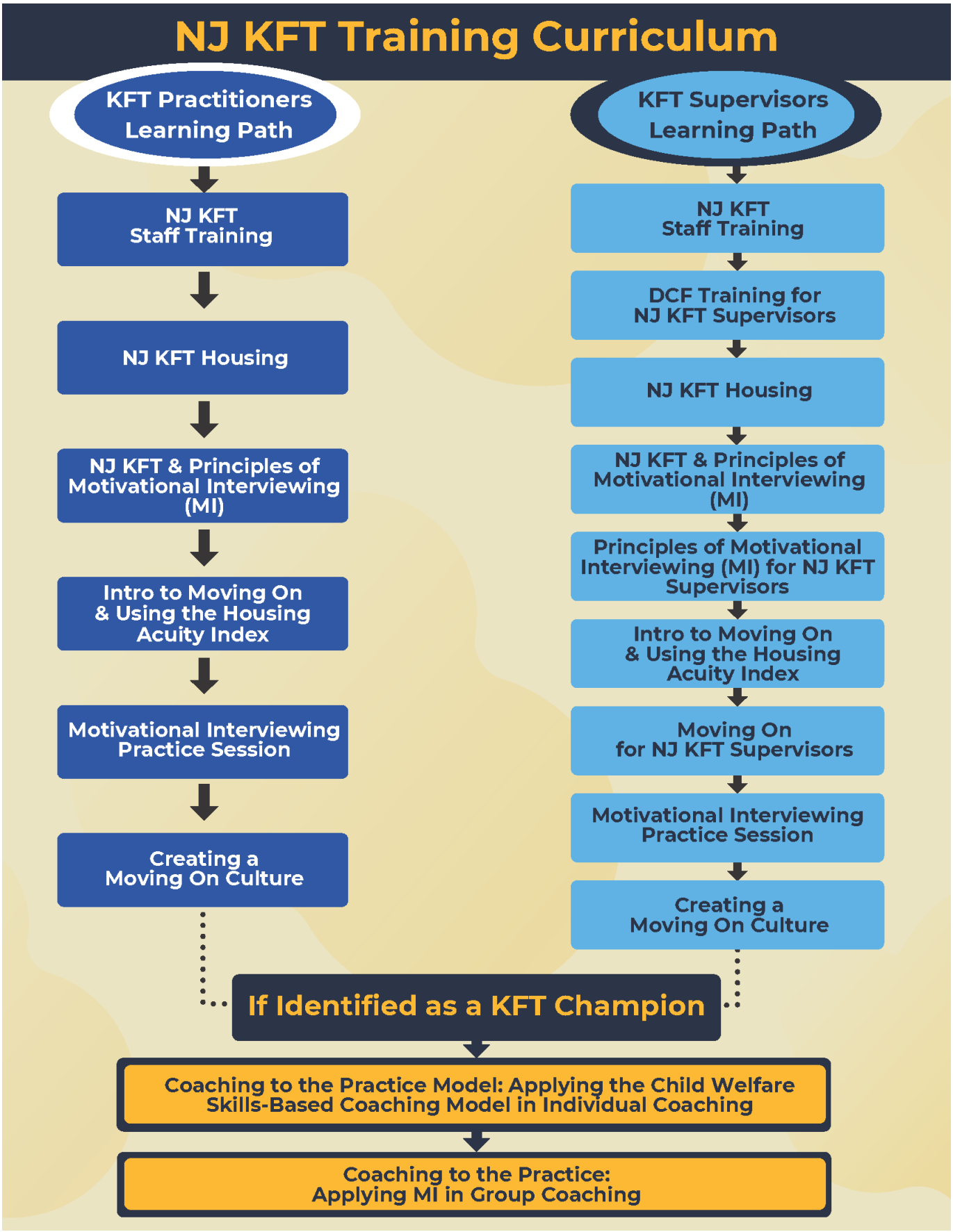
NJ KFT uses a purposeful process for selecting and hiring staff with the required skills, abilities, competencies and other characteristics to implement NJ KFT as intended. Please see the NJ KFT Interview Protocol located in Appendix H.

404 NJ KFT TRAINING

Skills-based training is necessary to promote acquisition of skills and information needed to carry out program services and competencies. Training alone, however, is not sufficient to ensure the successful application of knowledge and skills in practice. Supervision and on-the-job coaching are needed to reinforce skills and inspire staff confidence (NIRN, 2012). NJ KFT includes a comprehensive series of trainings, supervision, and coaching to support the successful delivery of program services.

All NJ KFT staff are required to complete and utilize NJ KFT trainings, applicable to their specific roles in NJ KFT, and developed coaching materials to promote competency in the NJ KFT Practice Model. Trainings offer in-depth and interactive sessions intended to strengthen staff's knowledge, skills, and competencies necessary to implement NJ KFT.

NJ KFT TRAINING



405 NJ KFT SUPERVISION

NJ KFT Program Managers provide supervision and clinical oversight to NJ KFT staff. They are responsible for overseeing that staff deliver, and are supported in the delivery of, services as described in the NJ KFT Logic Model and NJ KFT Practice Profile to ensure program fidelity. Fidelity to the program is essential to ensure the NJ KFT model is being implemented as intended, with the goal of producing positive program outcomes. Fidelity is measured in many ways for NJ KFT programming—through data collection and reporting to assess whether service activities are being delivered as outlined and through use of a fidelity tool (NJ KFT Observation Fidelity Tool) to measure the quality-of-service activities being delivered to ensure best practices are being followed. More information about the NJ KFT data collection and reporting can be found later in this section of the manual.

406 NJ KFT CLINICAL OVERSIGHT

NJ KFT programs include clinical interventions and, therefore, must include clinical oversight and support. Clinical supervision in NJ KFT programs must be provided by a fully licensed clinician, such as an LCSW or an LPC with proper education, training, and experience. Clinical supervision must be provided individually. In addition to individual supervision, group clinical supervision sessions can be utilized to enhance supervisory practice. Individual clinical supervision should be frequent and regular and must occur at least weekly. Group clinical supervision may be provided through team meetings on regular or as-needed frequencies. During both individual and group clinical supervision sessions, cases are presented, reviewed, and reflected upon to ensure clinical interventions and strategies are targeted to the family's needs, clinical best practices are adhered to, and families receive high-quality interventions.

407 NJ KFT FIDELITY MONITORING

Attending to NJ KFT fidelity is essential to ensuring the model is being implemented as intended to ensure families attain positive outcomes. Fidelity implies the practitioner is using NJ KFT as intended in a consistent and clearly defined way. Should the practitioners diverge or "drift" too far from the model, it may no longer be effective in achieving the identified outcomes.

NJ KFT Program Managers should evaluate staff competencies in the NJ KFT Essential Functions through direct observation and highlight areas for NJ KFT Champions to focus their coaching to help improve staff knowledge, skills, and competencies.

A NJ KFT Observation Fidelity Tool is in development. It is intended to assess the quality and consistency with which NJ KFT staff are implementing the NJ KFT practice model. The NJ KFT Observation Fidelity Tool will be based on the NJ KFT Essential Functions and observable behaviors outlined and described in the NJ KFT Practice Profile.

408 NJ KFT COACHING

In addition to training and supervision, NJ KFT staff will receive regular and consistent individual and group coaching by NJ KFT Champions as part of the NJ KFT Program Model. Coaching is non-clinical, individualized, and aimed at developing awareness of and improving staff's knowledge, skills, and competencies in the NJ KFT Practice Model. The Child Welfare Skills-Based Coaching Model is used to support individual coaching sessions. NJ KFT Champions are introduced to the structure and tools for integrating individual and group coaching into their practice through NJ KFT coaching training, coaching guides, and learning collaboratives.

409 SYSTEMS COLLABORATION AND NETWORKING

409.1 Systems Collaboration

Collaboration with other systems in the community is necessary to create a seamless and comprehensive system of care and support for individuals and families served by NJ KFT. Collaboration involves smooth and responsive referral efforts, ongoing telephone and electronic communication between programs, and face-to-face partnership in settings such as Family Team Meetings and Visitation Planning Meetings. Consent forms are necessary to permit family-specific written, verbal, and electronic communication between agencies within the system of support.

409.2 Networking

NJ KFT programs build and maintain connections with DCP&P and a network of community-based programs to create a system of support for families. Partnerships with other agencies and services help to ensure that the diverse needs of children and families are met and that culturally appropriate resources are accessible to the families being served. These collaborations are necessary to make sure that families' basic needs, as well as underlying needs are addressed.

NJ KFT programs should participate in events held by community-based providers, such as networking meetings and resource fairs to help educate the community about services provided by NJ KFT programs.

Networking between NJ KFT programs is an important activity that promotes sharing best practices, brainstorming solutions to common issues, and assisting one another in maintaining Program Model fidelity.

410 NJ KFT EVALUATION

410.1 Evaluation Purpose and Questions

The purpose of the NJ KFT program evaluation is to conduct a combined implementation and outcome study to provide information about the implementation of the NJ KFT model across sites and to determine the factors that support and/or deter the program from achieving its set goals. The NJ KFT evaluation seeks to answer the following questions:

- What are the characteristics and needs of the families enrolled in NJ KFT?
- What kinds of services have families enrolled in NJ KFT received?
- Have the families enrolled in NJ KFT remained stably housed?
- How has the NJ KFT program impacted families' wellbeing?
- How has the NJ KFT program impacted families' involvement with the child welfare system?
- What challenges and successes were encountered in implementing NJ KFT?
- How were challenges resolved?

410.2 Data Collection

As part of the data collection process, NJ KFT programs will be responsible for completing baseline family surveys and submitting quarterly service reports using a DCF template. Instructions for quarterly reporting can be found in Appendix I. The baseline family survey collects information on each family enrolled in NJ KFT including demographic information, risk factors, and family structure. It is completed by providers for each NJ KFT family within 30 days of enrollment in the NJ KFT program. In the quarterly service report, NJ KFT programs are asked to submit data related to staffing, families' use of services, and success and challenges for the quarter. Specific areas of inquiry include:

- Family Data—this includes service utilization and intermediate outcomes for each family served during the quarter. Intermediate outcomes are measured using the Arizona Self-Sufficiency Matrix. Services data are collected every quarter, but the intermediate outcomes data are submitted twice a year. A data reporting schedule is provided to NJ KFT programs every year.
- Narrative Data—NJ KFT programs are asked to submit brief narratives that describe their program's successes, challenges, and requests for technical assistance.

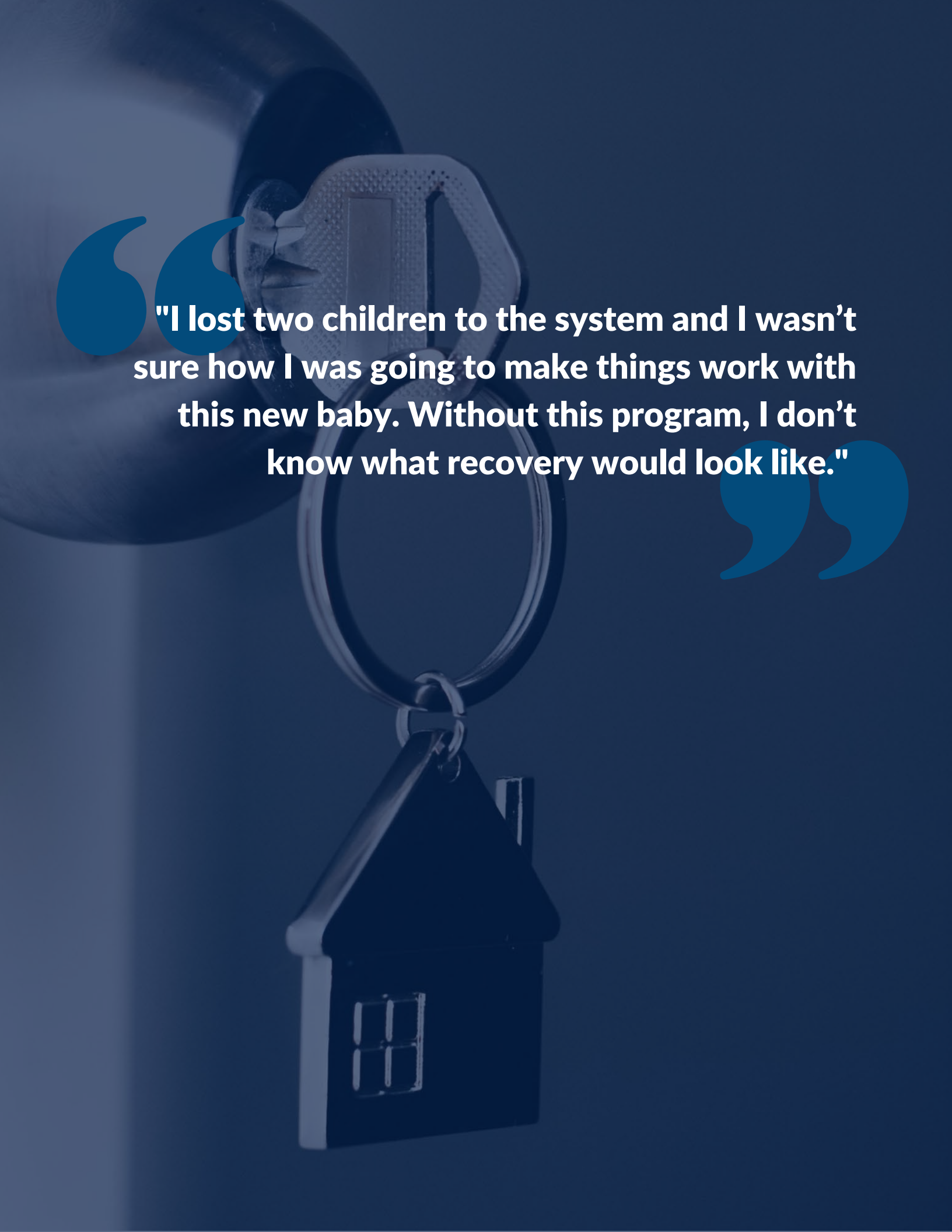
Quarterly service report data is submitted on a quarterly basis. Analyses are conducted using aggregate data from all NJ KFT Service Providers and at the provider-specific level.

410.3 Continuous Quality Improvement (CQI)

DCF utilizes a structured continuous quality improvement (CQI) process to identify areas needing improvement and analyze strengths. DCF is committed to the process of ongoing evaluation as a vehicle to learn and to develop solutions to improve the quality of services. NJ KFT programs participate in the following CQI and evaluation activities in collaboration with DCF, external evaluators, and/or consultants:

- Measure and report on standardized performance and outcome indicators;
- Develop and maintain clear and organized systems of data collection to seamlessly submit reports to DCF;
- Participate on implementation teams with DCF and existing and/or future NJ KFT grantees to support model development and;
- Meet with DCF staff and/or external evaluators/consultants at regular intervals to ensure implementation, evaluation and data reporting requirements are met. Regular evaluation and CQI meetings are held as follows:
    - Monthly individual and group calls with NJ KFT program managers
    - Quarterly CQI calls with NJ KFT program staff and DCF staff
    - At least 4 annual grantee meetings held in person, by phone, or through webinar.
    - At least two staff from each program shall participate in these meetings.

In addition to the above-listed CQI activities, DCF facilities data collection and CQI activities with NJ KFT parents to ensure the experiences of children and families inform and guide programmatic decisions.



"I lost two children to the system and I wasn't sure how I was going to make things work with this new baby. Without this program, I don't know what recovery would look like."

SECTION 500

NJ KFT FORMS AND TOOLS

500
NJ KFT FORMS AND TOOLS

501 NJ KFT FORMS

Note: *Each form below is linked to it's location within this manual. By selecting a form below, you will be re-directed to the location of that form within this manual.*

501.1 Checklists (pages 82–112)

a. Housing Inspection
b. Move-In Inspection
c. Voucher application
d. Apartment Comparison Checklist
e. Housing Preference Checklist
f. Mainstream Resources Checklist
g. Landlord Benefits checklist
h. Monthly Budget

501.2 Handouts and Marketing Material (pages 113–153)

i. Landlord Marketing Letter
j. Tenant Handbook
k. HUD Tips: Searching for a Unit
l. KFT Tips: Securing and Maintaining Housing
m. KFT Housing Flowchart
n. HUD Lease-Up Process

501.3 Evaluation and Assessment Forms (pages 154–173)

o. KFT Baseline Survey
p. KFT Services Survey
q. DCF Evaluation Consent

Housing Unit – Self Inspection Checklist

(To be used when preparing for inspection, prior to DCA's HQS inspection.)

	Yes	No
Is the exiting tenant residing in the unit?		
Is the electricity and gas on?		
If a room is designated as a living or sleeping room for one occupant, is it at least 70 square feet ((8.366 ft. x 8.366 ft.; 10 ft x 7 ft)?		
Does each habitable room have a ceiling height of at least 7 feet?		
Screens must be in all windows of the unit (during the period of May 1st through October 1st		
All windows must be operable and able to stay up when lifted (they sHould not be able to slam shut on someone's fingers when it is raised)		
An openable window is required or all bedrooms and living/habitable rooms		
An openable window or vent is required in the bathroom		
Each unit must have at least one battery operated or hardwired smoke detector on each level of the unit		
there must be an Operable oven with burners in the kitchen. A refrigerator must be in the unit, if the owner is supplying it		

	Yes	No
Exterior stairs, porches and balconies require a railing if the stairs have four or more consecutive steps. A railing is required if a porch or balcony is more than 30 inches above the ground		
Water Heaters should not be located in bedrooms or other living spaces. If water heaters are located in the kitchen or bathrooms, there must be a safety divider or shield installed. The water heater discharge line must be within 12 inches of the floor		

NOTE, FOR OWNERS/LANDLORDS:

To make the inspection process as efficient as possible, please ensure these key requirements exist before the actual inspection. If these requirements are not fulfilled, the unit will likely fail inspection.

Inspection Checklist

Housing Choice Voucher Program

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

OMB Approval No. 2577-0169
(Exp. 07/31/2022)

Public reporting burden for this collection of information is estimated to average 0.50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless that collection displays a valid OMB control number.

Assurances of confidentiality are not provided under this collection.

This collection of information is authorized under Section 8 of the U.S. Housing Act of l937 (42 U.S.C. 1437f). The information is used to determine if a unit meets the housing quality standards of the section 8 rental assistance program.

Privacy Act Statement. The Department of Housing and Urban Development (HUD) is authorized to collect the information required on this form by Section 8 of the U.S. Housing Act of 1937 (42 U.S.C. 1437f). Collection of the name and address of both family and the owner is mandatory. The information is used to determine if a unit meets the housing quality standards of the Section 8 rental assistance program. HUD may disclose this information to Federal, State and local agencies when relevant to civil, criminal, or regulatory investigations and prosecutions. It will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Failure to provide any of the information may result in delay or rejection of family participation.

Name of Family	Tenant ID Number	Date of Request (mm/dd/yyyy)
Inspector	Neighborhood/Census Tract	Date of Inspection (mm/dd/yyyy)
Type of Inspection ☐ Initial ☐ Special ☐ Reinspection	Date of Last Inspection (mm/dd/yyyy)	PHA

A. General Information

Inspected Unit **Year Constructed (yyyy)**

Full Address (including Street, City, County, State, Zip)

Number of Children in Family Under 6

Owner

Name of Owner or Agent Authorized to Lease Unit Inspected | Phone Number

Address of Owner or Agent

Housing Type (check as appropriate)

- ☐ Single Family Detached
- ☐ Duplex or Two Family
- ☐ Row House or Town House
- ☐ Low Rise: 3, 4 Stories, Including Garden Apartment
- ☐ High Rise; 5 or More Stories
- ☐ Manufactured Home
- ☐ Congregate
- ☐ Cooperative
- ☐ Independent Group Residence
- ☐ Single Room Occupancy
- ☐ Shared Housing
- ☐ Other

B. Summary Decision On Unit (To be completed after form has been filled out

☐ Pass ☐ Fail ☐ Inconclusive	Number of Bedrooms for Purposes of the FMR or Payment Standard	Number of Sleeping Rooms

Inspection Checklist

Item No.	1. Living Room	Yes Pass	No Fail	In-Conc.	Comment	Final Approval Date (mm/dd/yyyy)
1.1	Living Room Present					
1.2	Electricity					
1.3	Electrical Hazards					
1.4	Security					
1.5	Window Condition					
1.6	Ceiling Condition					
1.7	Wall Condition					
1.8	Floor Condition					

***** Room Codes: 1 = Bedroom or Any Other Room Used for Sleeping (regardless of type of room); 2 = Dining Room or Dining Area;
3 = Second Living Room, Family Room, Den, Playroom, TV Room; 4 = Entrance Halls, Corridors, Halls, Staircases; 5 = Additional Bathroom; 6 = Other

Item No.	1. Living Room (Continued)	Yes Pas	No Fail	In-Conc.	Comment	Final Approval Date (mm/dd/yyyy)
1.9	Lead-Based Paint Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?				Not Applicable	
	2. Kitchen					
2.1	Kitchen Area Present					
2.2	Electricity					
2.3	Electrical Hazards					
2.4	Security					
2.5	Window Condition					
2.6	Ceiling Condition					
2.7	Wall Condition					
2.8	Floor Condition					
2.9	Lead-Based Paint Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?				Not Applicable	
2.10	Stove or Range with Oven					
2.11	Refrigerator					
2.12	Sink					
2.13	Space for Storage, Preparation, and Serving of Food					
	3. Bathroom					
3.1	Bathroom Present					
3.2	Electricity					
3.3	Electrical Hazards					
3.4	Security					
3.5	Window Condition					
3.6	Ceiling Condition					
3.7	Wall Condition					
3.8	Floor Condition					
3.9	Lead-Based Paint Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?				Not Applicable	
3.10	Flush Toilet in Enclosed Room in Unit					
3.11	Fixed Wash Basin or Lavatory in Unit					
3.12	Tub or Shower in Unit					
3.13	Ventilation					

Item No. 4. Other Rooms Used For Living and Halls	Yes Pass	No Fail	In-Conc.	Comment	Final Approval Date (mm/dd/yyyy)
4.1 Room Code* and Room Location ☐	(Circle One) Right/Center/Left			(Circle One) Front/Center/Rear ____Floor Level	
4.2 Electricity/Illumination					
4.3 Electrical Hazards					
4.4 Security					
4.5 Window Condition					
4.6 Ceiling Condition					
4.7 Wall Condition					
4.8 Floor Condition					
4.9 Lead-Based Paint Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?				☐ Not Applicable	
4.10 Smoke Detectors					
4.1 Room Code* and Room Location ☐	(Circle One) Right/Center/Left			(Circle One) Front/Center/Rear ____Floor Level	
4.2 Electricity/Illumination					
4.3 Electrical Hazards					
4.4 Security					
4.5 Window Condition					
4.6 Ceiling Condition					
4.7 Wall Condition					
4.8 Floor Condition					
4.9 Lead-Based Paint Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?				☐ Not Applicable	
4.10 Smoke Detectors					
4.1 Room Code* and Room Location ☐	(Circle One) Right/Center/Left			(Circle One) Front/Center/Rear ____Floor Level	
4.2 Electricity/Illumination					
4.3 Electrical Hazards					
4.4 Security					
4.5 Window Condition					
4.6 Ceiling Condition					
4.7 Wall Condition					
4.8 Floor Condition					
4.9 Lead-Based Paint Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?				☐ Not Applicable	

Item No.	4. Other Rooms Used For Living and Halls	Yes Pass	No Fail	In-Conc.	Comment	Final Approval Date (mm/dd/yyyy)
4.1	Room Code * and Room Location	(Circle One) Right/Center/Left			(Circle One) Front/Center/Rear ____Floor Level	
4.2	Electricity/Illumination					
4.3	Electrical Hazards					
4.4	Security					
4.5	Window Condition					
4.6	Ceiling Condition					
4.7	Wall Condition					
4.8	Floor Condition					
4.9	Lead-Based Paint Are all painted surfaces free of deteriorated paint?				Not Applicable	
	If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?					
4.10	Smoke Detectors					
4.1	Room Code* and Room Location	(Circle One) Right/Center/Left			(Circle One) Front/Center/Rear ____Floor Level	
4.2	Electricity/Illumination					
4.3	Electrical Hazards					
4.4	Security					
4.5	Window Condition					
4.6	Ceiling Condition					
4.7	Wall Condition					
4.8	Floor Condition					
4.9	Lead-Based Paint Are all painted surfaces free of deteriorated paint?				Not Applicable	
	If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?					
4.10	Smoke Detectors					
	5. All Secondary Rooms (Rooms not used for living)					
5.1	None Go to Part 6					
5.2	Security					
5.3	Electrical Hazards					
5.4	Other Potentially Hazardous Features in these Rooms					

Item No.	6. Building Exterior	Yes Pass	No Fail	In - Conc.	Comment	Final Approval Date (mm/dd/yyyy)
6.1	Condition of Foundation					
6.2	Condition of Stairs, Rails, and Porches					
6.3	Condition of Roof/Gutters					
6.4	Condition of Exterior Surfaces					
6.5	Condition of Chimney					
6.6	Lead Paint: Exterior Surfaces Are all painted surfaces free of deteriorated paint?				Not Applicable	
	If not, do deteriorated surfaces exceed 20 square feet of total exterior surface area?					
6.7	Manufactured Home: Tie Downs					
	7. Heating and Plumbing					
7.1	Adequacy of Heating Equipment					
7.2	Safety of Heating Equipment					
7.3	Ventilation/Cooling					
7.4	Water Heater					
7.5	Approvable Water Supply					
7.6	Plumbing					
7.7	Sewer Connection					
	8. General Health and Safety					
8.1	Access to Unit					
8.2	Fire Exits					
8.3	Evidence of Infestation					
8.4	Garbage and Debris					
8.5	Refuse Disposal					
8.6	Interior Stairs and Commom Halls					
8.7	Other Interior Hazards					
8.8	Elevators					
8.9	Interior Air Quality					
8.10	Site and Neighborhood Conditions					
8.11	Lead-Based Paint: Owner's Certification				Not Applicable	

If the owner is required to correct any lead-based paint hazards at the property including deteriorated paint or other hazards identified by a visual assessor, a certified lead-based paint risk assessor, or certified lead-based paint inspector, the PHA must obtain certification that the work has been done in accordance with all applicable requirements of 24 CFR Part 35. The Lead -Based Paint Owner Certification must be received by the PHA before the execution of the HAP contract or within the time period stated by the PHA in the owner HQS violation notice. Receipt of the completed and signed Lead-Based Paint Owner Certification signifies that all HQS lead-based paint requirements have been met and no re-inspection by the HQS inspector is required.

C. Special Amenities (Optional)

This Section is for optional use of the HA. It is designed to collect additional information about other positive features of the unit that may be present. Although the features listed below are not included in the Housing Quality Standards, the tenant and HA may wish to take them into consideration in decisions about renting the unit and the reasonableness of the rent.
Check/list any positive features found in relation to the unit.

D. Questions to ask the Tenant (Optional)

1. Living Room

- [ ] High quality floors or wall coverings
- [ ] Working fireplace or stove Balcony,
- [ ] patio, deck, porch Special windows
- [ ] or doors
- [ ] Exceptional size relative to needs of family
- [ ] Other: (Specify)

2. Kitchen

- [ ] Dishwasher
- [ ] Separate freezer
- [ ] Garbage disposal
- [ ] Eating counter/breakfast nook
- [ ] Pantry or abundant shelving or cabinets
- [ ] Double oven/self cleaning oven, microwave
- [ ] Double sink
- [ ] High quality cabinets
- [ ] Abundant counter-top space
- [ ] Modern appliance(s)
- [ ] Exceptional size relative to needs of family
- [ ] Other: (Specify)

3. Other Rooms Used for Living

- [ ] High quality floors or wall coverings
- [ ] Working fireplace or stove Balcony,
- [ ] patio, deck, porch Special windows
- [ ] or doors
- [ ] Exceptional size relative to needs of family
- [ ] Other: (Specify)

4. Bath

- [ ] Special feature shower head
- [ ] Built-in heat lamp
- [ ] Large mirrors
- [ ] Glass door on shower/tub
- [ ] Separate dressing room
- [ ] Double sink or special lavatory
- [ ] Exceptional size relative to needs of family
- [ ] Other: (Specify)

5. Overall Characteristics

- [ ] Storm windows and doors
- [ ] Other forms of weatherization (e.g., insulation, weather
- [ ] stripping) Screen doors or windows
- [ ] Good upkeep of grounds (i.e., site cleanliness, landscaping,
- [ ] condition of lawn)
- [ ] Garage or parking facilities
- [ ] Driveway
- [ ] Large yard
- [ ] Good maintenance of building exterior
- [ ] Other: (Specify)

6. Disabled Accessibility

Unit is accessible to a particular disability. ☐ Yes ☐ No
Disability

1. Does the owner make repairs when asked? Yes ☐ No ☐
2. How many people live there? ☐
3. How much money do you pay to the owner/agent for rent? $ _____
4. Do you pay for anything else? (specify) _____
5. Who owns the range and refrigerator? (insert O = Owner or T = Tenant) Range _____ Refrigerator _____ Microwave ☐
6. Is there anything else you want to tell us? (specify) Yes ☐ No ☐

E. Inspection Summary/Comments (Optional)

Provide a summary description of each item which resulted in a rating of "Fail" or "Pass with Comments."

Tenant ID Number	Inspector	Date of Inspection (mm/dd/yyyy) Address of Inspected Unit

Type of Inspection Initial Special Reinspection

Item Number Reason for "Fail" or "Pass with Comments" Rating

Continued on additional page Yes ☐ No ☐

Move-In/Move Out Inspection Checklist

Note: This is a checklist to be used when conducting a move-in (and move out) inspection. It may be used to negotiate repairs, but it is also a way for tenants to document existing issues to prevent being charged for pre-existing damage at move out.
Units with health and safety problems are unacceptable, in tight housing markets, tenants must often negotiate units with some deficiencies (e.g., scuffed floors, torn carpet etc.). KFT housing teams should support the process of accurately documenting the condition of the unit at move in, to reduce the likelihood of losing a security deposit at move out.
It is also strongly recommended for this checklist to be ***accompanied by photos and/or video of the unit*** taken during the move-in inspection before the tenant occupies the unit; and again, at the time of move out.

Directions: This worksheet is designed to help with the apartment inspection at move in and move out. Examine everything on this list and write down ***ALL*** the problems you see. This is important for two reasons. First, the list can help with retaining the security/damage deposit back at move out; because it list the issues that existed at move in. Second, it allows for the tenant and landlord to discuss issues that should be fixed and by when.

Request that the landlord be present for the unit inspection; and initial the items he/she agrees to repair. Be sure that both landlord and tenant sign and date the form. If the landlord cannot conduct the inspection, share a completed copy with him/her and ask that they sign it and return it. KFT practitioners should retain a copy of this completed form, along with any photos/videos of the unit as well. Remember, the tenant should always be provided a copy of this form.

Move-in inspection for:

_____
(Name of tenant and address of apartment)

_____

Item	Move In	Move Out	N/A	Comments
KITCHEN				
Is there adequate lighting in the kitchen?				
Is there an electrical outlet in the kitchen that works?				
Is there a sink with hot and cold running water? Does the water drain quickly?				

Item	Move In	Move Out	N/A	Comments
Is the stove in good working condition? *(Do the burners work? Does the oven work? If it's a gas stove, do you smell gas when the stove is turned off? Are there any broken or missing parts?)*				
Is the refrigerator in good working condition? *(Do the refrigerator and the freezer seem cold enough? Are there any broken or missing parts?)*				
If there is a dishwasher, is it in good working condition?				
If there is a garbage disposal, does it work?				
BATHROOM				
Is the toilet in adequate condition? *(Flush the toilet—Does it empty? Does it fill? Does the water keep running after the bowl fills? Does it look like there have been leaks around the toilet? Where is the shut-off valve; does it work?)*				
Is there a sink with hot and cold running water? Does the water drain quickly?				
Is there a tub and/or shower with hot and cold running water? Does the water drain quickly?				
Is there ventilation from a fan or window in the bathroom?				
GENERAL UNIT CONDITION				
If there is air conditioning, does it work?				
Does the furnace work? *(If it's cold enough outside for the furnace to be turned on, is there enough heat? Too much? Is the apartment temperature hotter or colder than the thermostat setting?)*				
Do all the windows open and close? Do the windows have working locks?				
Are any of the windows broken? Are any of the storm windows or screens broken or missing?				
Do all windows have curtains, blinds, shades, or other coverings?				
Is there a working deadbolt lock on the front/back door of the apartment?				

Item	Move In	Move Out	N/A	Comments
Do you see any water stains on the walls or ceilings? If so, has the leak been fixed?				
If there are hardwood floors, do you see any deep scratches, burns, black marks, or places where the wood is worn down?				
If there is carpeting, do you see any stains, burns, or tears?				
Are there any holes or large cracks in the walls or ceiling?				
Are there places where the paint is peeling or flaking? *(If so, find out if the unit was built before 1978. If so, and if children will be living in the unit, repair of the paint is very important because it could cause lead poisoning.)*				
Does the unit have a working smoke detector? (Ask how you can test it)				
Do you see any exposed wires, missing light switch or outlet covers, or broken or missing ceiling lights?				
Is there any evidence of bugs or rodents?				
GENERAL BUILDING CONDITION				
Is there a fire exit that is easily accessible?				
Is there adequate lighting in the stairwells and hallways?				
Are the stairwells and hallways free of garbage, graffiti, and hazards?				
Are the mailboxes locked and in good condition?				
Are there problems with the yard: trash, broken fence, hazardous sidewalk, etc.?				
BEDROOM 1				
Do all the windows open and close? Do the windows have working locks?				
Are any of the windows broken? Are any of the storm windows or screens broken or missing?				
Do all windows have curtains, blinds, shades, or other coverings?				

Item	Move In	Move Out	N/A	Comments
Does the bedroom door open and shut safely?				
Do you see any water stains on the walls or ceilings? If so, has the leak been fixed?				
Do you see any deep scratches, burns, black marks, or other floor damage?				
If there is carpeting, do you see any stains, burns, or tears?				
Are there any holes or large cracks in the walls or ceiling?				
Are there places where the paint is peeling or flaking? *(If so, find out if the unit was built before 1978. If so, and if children will be living in the unit, repair of the paint is very important because it could cause lead poisoning.)*				
Do you see any exposed wires, missing light switch or outlet covers, or broken or missing ceiling lights?				
Does the closet have a working door and is free from debris?				
BEDROOM 2				
Do all the windows open and close? Do the windows have working locks?				
Are any of the windows broken? Are any of the storm windows or screens broken or missing?				
Do all windows have curtains, blinds, shades, or other coverings?				
Does the bedroom door open and shut safely?				
Do you see any water stains on the walls or ceilings? If so, has the leak been fixed?				
Do you see any deep scratches, burns, black marks, or other floor damage?				
If there is carpeting, do you see any stains, burns, or tears?				
Are there any holes or large cracks in the walls or ceiling?				
Are there places where the paint is peeling or flaking? *(If so, find out if the unit was built before 1978. If*				

Item	Move In	Move Out	N/A	Comments
so, and if children will be living in the unit, repair of the paint is very important because it could cause lead poisoning.)				
Do you see any exposed wires, missing light switch or outlet covers, or broken or missing ceiling lights?				
Does the closet have a working door and is free from debris?				
BEDROOM 3				
Do all the windows open and close? Do the windows have working locks?				
Are any of the windows broken? Are any of the storm windows or screens broken or missing?				
Do all windows have curtains, blinds, shades, or other coverings?				
Does the bedroom door open and shut safely?				
Do you see any water stains on the walls or ceilings? If so, has the leak been fixed?				
Do you see any deep scratches, burns, black marks, or other floor damage?				
If there is carpeting, do you see any stains, burns, or tears?				
Are there any holes or large cracks in the walls or ceiling?				
Are there places where the paint is peeling or flaking? *(If so, find out if the unit was built before 1978. If so, and if children will be living in the unit, repair of the paint is very important because it could cause lead poisoning.)*				
Do you see any exposed wires, missing light switch or outlet covers, or broken or missing ceiling lights?				
Does the closet have a working door and is free from debris?				
# of Keys				
Front Door				
Back Door				

Item	Move In	Move Out	N/A	Comments
Mailbox				
Garage				
Other				
External Area (Porch, Garage etc.)				
Are there any holes or large cracks in the walls or ceiling?				
Are there places where the paint is peeling or flaking? *(If so, find out if the unit was built before 1978. If so, and if children will be living in the unit, repair of the paint is very important because it could cause lead poisoning.)*				
Do you see any exposed wires, missing light switch or outlet covers, or broken or missing ceiling lights?				

For Move In*: We agree that the information above accurately represents the condition of the unit when the tenant moved in. If applicable, the landlord agrees to make the repairs initialed on this form within the agree upon timeframe. The landlord and tenant each received a copy of this form.*

Tenant Signature	**Date**
Tenant Signature	**Date**
Landlord Signature	**Date**

****

For Move Out: *We agree that the information above accurately represents the condition of the unit when the tenant moved out. I/We (the tenant(s)) understand that unless otherwise noted, the tenant is responsible for any damages as indicated in the lease agreement; these may be deducted from the security deposit at the time of move-out. The landlord and tenant each received a copy of this form.*

Tenant Signature	**Date**
Tenant Signature	**Date**
Landlord Signature	**Date**

If this is a move out inspection, please list tenant's forwarding address:

Housing Voucher Application Checklist

About this checklist: Before submitting a complete voucher application packet, KFT teams support the family in gathering documentation. Gathering documentation often requires extra time as families experiencing homelessness and housing instability may often misplace or lose identifying documents. All efforts should be made to expedite the process of gathering documents by working in partnership with State and local agencies (like the NJ DMV – the Division of Motor Vehicles) to secure items like photo identification. This checklist may be used as a guide to support the process of gathering documents.

Important Reminders:

- While gathering documents and managing/sharing the family's personal information KFT teams must always maintain confidentiality.
- KFT teams should work in close collaboration with the parent (and other partners when applicable, for example DCP&P) until the voucher application is complete and all supporting documents are received.

Document Type	Yes	No	N/A	Comment
KFT Housing Voucher Application Packet				
- Housing Voucher Application				
- Tenant Information Form (TIF)				
- KFT Authorization for Release of Information.				
- Declaration of Citizenship				
- Certification of Zero Income, *if applicable.*				
- Certification of Disability, *if applicable. This must be signed by a physician or APN; if the person is not receiving SSI/SSD.)*				
Photo ID for every member of the household 18 years and older. (Copies) This may include a driver's license or non-driver's photo ID. A veteran's ID can also be used, if applicable.				

Social security Cards for every member of the household. (Copies)				
Birth certificates for every member of the household. (Copies)				
Incomes Sources *(Please review the list below and include copies of all items that apply.)*				
- The last 4 consecutive paycheck stubs, or a notarized statement of proof of income. If working "under the table" then a notarized letter may be provided that includes the average monthly wages.				
- Social Security Benefit/Award letter. (This includes a letter from the Social Security Administration stating benefits).				
- Child Support, *if applicable.* (This may include the following: a current print out of child support disbursement history, or a notarized letter from the payer stating how much and how often child support payment is made or the applicant may provide a notarized letter, if the payer is unable/unwilling to supply the requested letter).				
- Award letter for Food Stamps and/or TANF				
- Full Time Student Verification				
- Zero Income Form (This must be notarized)				
- Unemployment/ Disability/ Worker Compensation				
- Veteran's Benefits (This includes a statement from the Veterans Administration or check stubs.)				
Asset Verification *(Please review the list below and include copies of all items that apply.)*				
- Bank Statement(s) (checking, savings, etc.)				
- Pension Statement (this should be on the company's letterhead and include the amount of benefits or check stubs).				
- **Other Assets: (please list)**				

YOUR LOGO HERE

Street Address, City, State, Zip code
Website & Telephone Number 555.555.5555

Apartment Comparison Checklist

About this checklist: Tenants and KFT staff may want to use this checklist to compare different apartments/units, especially if when viewing a number of units in one day. Despite the often-tight housing market that limits unit options, tenants must be encouraged to view different units, especially since there are children in the household. Moving frequently can be very disruptive for children – especially when a move involves enrolling in a new school. With this in mind, KFT teams should support family's in finding a unit (and neighborhood) that will work for them in the long term.

Directions: Use this checklist to compare different apartments. As you are viewing an apartment, turn appliances on and off to ensure that they are in good, working condition, test the water pressure in the kitchen and bathroom, check the locks on the windows and doors, etc. Do not be afraid to ask the landlord any questions you may have, particularly about the terms and conditions of the lease. Note that you may have already asked the landlord about the terms and conditions when you first called about the unit, but ask again to verify the information you received. You may also want to ask the landlord what type of routine maintenance is done on the apartment and how repair issues are handled. Finally, talk to current tenants to find out how they like living in the building. Do they feel safe and secure? What is the noise level? Is the landlord responsive about repairs? Moving can be expensive and disruptive, so it is important to find a unit that meets your needs.

Terms and Conditions	**Apt. 1**	**Apt. 2**	**Apt. 3**
Address of unit			
Date available			
Application fee			
Security/damage deposit			
Pet rules/deposit			
Rent amount			

Rent due date			
Length of lease			
Penalty for breaking lease			
Utilities included			
Apartment Features	**Apt. 1**	**Apt. 2**	**Apt. 3**
Number of bedrooms			
Location in building (basement, ground level, upper level)			
Furnished			
Eat-in kitchen			
Separate dining area			
Air conditioning			
Hardwood Floors			
Carpet			
Paint/wall condition			
Closet space/storage			
Windows/natural light			
Window coverings			
Ample outlets in each room			
Water pressure			
Handicap accessible			

Kitchen	**Apt. 1**	**Apt. 2**	**Apt. 3**
Age/condition of refrigerator			
Age/condition of stove/oven			
Dishwasher?			
Garbage Disposal?			
Microwave?			
Cupboard space/storage			
Counter space			
Community	**Apt. 1**	**Apt. 2**	**Apt. 3**
Laundry facilities			
Elevator			
Secured entrance			
Adequate outside lighting			
Parking available			
Noise level			
On-site playground or proximity to park			
Proximity to public transportation			
Proximity to work/school			
Proximity to grocery store, bank, post office, etc.			

General Notes/Comments	Apt. 1	Apt. 2	Apt. 3

Agency Name
Street Address
City, State, Zip code
Telephone Number
Fax Number

Street Address, City, State, Zip code
Website & Telephone Number 555.555.5555

Housing Preferences Checklist

About this checklist: Before families begin their housing search, they should carefully think through the features of an apartment, building, and neighborhood that are most important to them. KFT teams can support parents in this process by using this checklist to help them determine the features they must have, those they would prefer, and those they can live without. Once families have made these decisions, they will be able to conduct a more targeted housing search.

Note, in tight housing markets where unit options are limited KFT teams support families in making decisions that best align both the family's needs and housing preferences.

Apartment/Unit	I Must Have	I Would Prefer	I Could Do Without
One bedroom (as opposed to an efficiency)			
More than one bedroom			
Furnished unit			
Washer and dryer in unit			
Dishwasher			
Air conditioning			
Utilities included			
Closets and storage			
One level (no stairs)			
Private bathroom			

Other:			
Other:			

Building	I Must Have	I Would Prefer	I Could Do Without
Specific type of building (single family, duplex, multifamily)			
Secured entrance			
On-site laundry facilities			
Yard/playground			
Off-street parking			
Handicap accessibility			
Elevator			
Pets allowed			
Storage space			
On quiet street			
Other:			
Other:			

Neighborhood	I Must Have	I Would Prefer	I Could Do Without
Near public transportation			
Near major roads/highways			
Near schools/daycare			
Near work			
Near healthcare and supportive services			
Near parks/play areas/public library			
Near family/friends			
Near grocery store & shopping			
Near religious and recreation facilities			
Children can play outside			
Quiet			
Other:			
Other:			

Agency Name
Address
City, State, Zip code
Telephone Number
Fac Number

Mainstream Benefits Checklist

Note: Families and individuals experiencing homelessness often require a wide range of services that no single agency has the resources or expertise to provide. KFT Providers should encourage parents/families to participate in all of the mainstream benefit and service programs for which they are eligible. By encouraging parents to participate in, and connect to, mainstream benefits programs, KFT Providers can focus their efforts on housing and support the family's long-term well-being.

Tips: KFT Practitioners can use this checklist to assess which mainstream benefits and services the family receives, identify which benefits and services the family is eligible for, and monitor the family's application process.

Note: KFT Teams should assemble a list of the points of contact for each mainstream program to share with staff and/or families.

Family Name: _____

Case ID: _____

Intake Date: _____

Mainstream Benefit	Already Receives? Yes/No	Eligible? Yes/No/Don't Know	Application Date	Outcome	Notes/Comments
TANF					
SSI					
SSDI					
Food Stamps					
Job Training/ Employment					
Medicaid					
Medicare					
Veterans' Health Care					

SCHIP – State Children's Health Insurance Program					
Mental Health Care					
Substance Abuse Treatment					
Other Benefits					

LANDLORD BENEFITS CHECKLIST

Why do landlords like working with [name of your organization]?

About this Tool: This checklist is a tool to advertise KFT to potential landlords. The benefits listed are examples of services provided by KFT Providers across the network. Be sure to update the list so that it represents your KFT program accurately.

User Tips: As part of the team marketing materials, it is important that the piece looks professional and catches people's attention. You may want to customize the checklist by including your organization's name and logo. Similarly, you could use graphics, photos (e.g., a photo of one of your program participants talking to one of your participating landlords), and/or colored paper to give it more of a polished look. This checklist could be mailed out to landlords in your community along with other program materials (e.g., a program brochure, newsletter, or annual report). Or, KFT staff can use it as a "leave behind" piece when they meet with prospective landlords. Finally, send copies over to your local landlord organization to distribute at their next meeting. Even better, see if you can do a short presentation at the next meeting that includes landlord and housing developers!

[INSERT 2-3 SENTENCE INTRODUCTION ABOUT THE KFT PROGRAM.]

Landlords gain several benefits from participating in KFT. Consider the following advantages:

- ✓ Eliminate advertising costs. Working with KFT gives you access to a pool of ready-to-rent tenants. Just call us up when you have a vacant unit, and we'll immediately match you with a family who is looking for a home.

- ✓ Security deposits. Our team aims to help families get back up on their feet. We've found that many families can afford the monthly rent, but have difficulty saving enough money for their security deposit. As a result, we help families put together this one-time payment.

- ✓ Guaranteed rent payments. Families are pre-screened and have a stable source of rental income. However, should issues arise, we can access limited funding to help families get through rough spots.

- ✓ On demand Supports. Our KFT teams are always available, providing an array of support services to families that ensure they stabilize in their new environment and receive the support they need to thrive.

- ✓ Neutral party to mediate problems. Despite the best efforts, problems are sometimes inevitable. However, when problems arise, it can be reassuring to know there is someone to call. We care as

much about our relationship with our landlords as we do our families. KFT requires partnership from everyone! The role of KFT staff is to be a neutral party, ensuring that everyone is treated fairly and that problems are resolved quickly. This includes help transitioning families during the moving in (and moving out) process, as well as mitigating conflicts, if needed.

✓ Satisfaction from helping others. Everyone deserves a safe and affordable place to call home. By helping to provide housing for vulnerable families, you play an integral role in helping families build better lives while making your community a better place to live.

Interested but still unsure? Connect with one of our participating landlords:

- [NAME, NUMBER]
- [NAME, NUMBER]

[Note: Remember to ask for permission before listing someone's name. And, make sure they will give the KFT a good reference!]

And, of course, feel free to call us at anytime. We would love the opportunity to work with you.

- [PROVIDE YOUR CONTACT INFORMATION]

Contact:
Agency Name
Address
City, State, Zip code
Telephone Number
Fax Number

Monthly Budget Worksheet

Income from Work			0
Housing Subsidy			0
Child Support			0
TANF			0
SSI			0
SSDI			0
Other:			0
Other:			0
Other:			0
			0

Total Monthly Income	$0
Total Monthly Expenditures	$0
	0

Rent/Rent Portion			0
Groceries			0
Clothing			0
Childcare			0
Car Payment			0
Car Insurance			0
Car Maintenance & Fees			0
Car - Gasoline			0
Public Transportation			0
Medical/Prescriptions			0
Dental			0
Vision			0
Internet Service			0
Telephone - Cell			0
Utilities (gas, electric, water etc.)			0
Cable			0
Laundry & Drycleaning			0
Toiletries & Household Products			0
Credit Card Payment			0
Student Loan Payment			0
Entertainment/Recreation			0
Tuition Fees			0
Pocket Money			0
Savings			$0
Child Support			$0
Other:			0
Other:			0
			0

Street Address, City, State, Zip code
Website & Telephone Number 555.555.5555

Landlord Marketing Letter

About this tool: Use this marketing letter separate or in combination with the "landlord benefits checklist" to advertise KFT to landlords in your community. Customize it based on your own program and create print outs on your agency letterhead.
Also, remember to include a telephone number so that landlords can connect with you and your agency.

[Name]
[Address]
[City, State, Zip Code]
[Date]

Dear [*Name of Landlord*]:

We would like to take this opportunity to introduce you to our organization and one of our most exciting programs. *[Name of organization/ KFT]* is an innovative model designed to support families experiencing homelessness and/or housing instability to achieve safe and stable housing.

We know rental units are often low in stock and working with tenants who've had housing issues in the past can be risky. However, our families are committed to succeeding, and ***we are committed to helping them succeed***. Yet, we cannot do it alone – landlords literally hold the keys. That's why we offer landlords a number of incentives, including:

- Security deposits. Our team aims to help families get back up on their feet. We've found that many families can afford the monthly rent, but have difficulty saving enough money for their security deposit. As a result, we help families put together this one-time payment.

- Guaranteed rent payments. Families are pre-screened and have a stable source of rental income. However, should issues arise, we can access limited funding to help families get through rough spots.

- 24/7 Support Services. Our KFT teams are always available, providing an array of support services to families that ensure they stabilize in their new environment and receive the support they need to thrive.

[Name of your agency - KFT] has helped to stabilize families in housing since *[date established]*. KFT's success is based on strong relationships (with families and community partners alike) and a commitment to following through on our promises. If you would like to speak with other landlords we've worked with, we 'd be happy to provide you with some references.

We hope that you keep us in mind when you have future openings at your properties. We would love the opportunity to work with you.

Sincerely,

[Your Name]
[Your Number]

ABOUT THIS DOCUMENT

This sample tenant manual was developed by the Center for the Study of Social Policy in collaboration with the Corporation for Supportive Housing. It is specifically designed as a resource for supportive housing providers working with families, especially those families involved with the child welfare system.[1] The goal was to develop a tenant manual that could be easily adapted for sites that are providing supportive housing for families. While it may be most useful to programs serving families at a single site such as an apartment building or a cluster of apartment units managed by the same housing provider, we encourage providers of scattered site housing to review and adapt with landlords as you find useful.

This manual is part of a suite of tools and resources that have been developed because families have a unique set of needs and need environments that can support those needs. It is hoped that this document will be used in conjunction with those other tools. Used together, the tools serve to support the type of practice and structural changes that will help programs work with families effectively. The guide builds off an existing tenants' manual developed by Fox Point, a family supportive housing apartment building in New York City, provided through Palladia, Inc. We thank them for sharing this resource with us as it was foundational to this work.

TIPS FOR USE

We have designed this document to be easily adapted by supportive housing programs.

- Programs in the process of developing a first time tenant's manual for may want to simply build off the document as is. Places where program specific insertions will be required are delineated by bright blue text prompts or a set of brackets and two asterisks. Searching for the character string: [**] should help you quickly identify those places where program specific insertions are needed.

- There are a number of places where the text in the tenant guide has direct implications for program practice. We have flagged those places with a blue text box with the title "Practice Note." Programs will need to ensure that their practice aligns with these recommendations or edit the suggested text.

- Programs with an existing tenant guide in use may want to review the table of contents in this guide to identify if there are topics covered here which may not be covered in their existing manuals. Some sections such as those on child abuse and neglect, domestic

[1] From October 1, 2012 through September 30, 2017 five sites around the country received federal funding to implement *"Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System".*

violence and bullying may not be standard to tenant manuals but are important when serving families with children.

Please feel free to borrow liberally from the document and let us know how you are using it and adapting it. We welcome your comments by email at info@cssp.org.

FUNDAMENTALS

In our adaption we have stressed the following:

- Clear understandable language with a goal of an 8th grade reading level
- A collaborative tone which emphasizes the shared goal of keeping all families safe and stable
- Accessible support around common problems families face
- Support for the parent's role in managing child behavior
- Clarity about the things that constitute lease violations and a commitment to early work with residents to address these issues
- Clear processes and protocols for dealing with conflicts and issues

We recognize that many of these are not unique to families with children as they are fundamental to quality supportive housing in general.

TENANT GUIDE & WELCOME PACKET

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

[**Click above to insert logo]

Welcome!!!

Dear Tenant,

Welcome to your new home and to our community. We are looking forward to having your family with us and getting to know you. Please stop by the office and introduce yourself to our friendly staff. We look forward to meeting you, and hope you are settling into your new home comfortably.

Our goal is to make sure that you have a home for you and your family. We also want to help you connect to what you need to succeed.

Our mission is to provide a caring environment to all the families who live here. We encourage you to use all of the services we offer here.

To help everyone in our community be safe and feel at home, we have put together this Tenant Handbook. This handbook should help answer questions about building rules, regulations, and being good neighbors to each other. If you have additional questions after you and your case manager review the handbook, please feel free to visit the office and a staff member will assist you.

Sincerely,

Click or tap here to enter text., Program Director

MAP

Here is what you can find in the neighborhood. Go explore!

[**Click to insert picture of map above]

	Address	*Contact Information*
Buildings	Click or tap here to enter text.	Click or tap here to enter text.
Schools	Click or tap here to enter text.	Click or tap here to enter text.
Parks	Click or tap here to enter text.	Click or tap here to enter text.
Grocery Stores	Click or tap here to enter text.	Click or tap here to enter text.
WIC Centers	Click or tap here to enter text.	Click or tap here to enter text.
Community health clinics	Click or tap here to enter text.	Click or tap here to enter text.
Other important resources for children and families	Click or tap here to enter text.	Click or tap here to enter text.

TABLE OF CONTENTS

SECTION 1: BUILDING MANAGEMENT, TENANCY AND OPERATION

PROPERTY MANAGEMENT

Click or tap here to enter text.

Click or tap here to enter text.

The property management company is your point of contact for the following:

- paying your rent,
- getting something fixed in your apartment or in the building,
- complaints or concerns about staff and/or other residents
- and other day-to-day issues.

The property management company is not in charge of your supportive housing case manager or the other social services you are receiving. If you have concerns about these please contact: Click or tap here to enter text. or talk with your case manager.

LEASE

Your lease is a legal contract between you (the tenant) and us (the landlord). It is a promise between us. You promise to follow the rules we have for keeping your home safe and being a good neighbor. We promise to help you maintain your home and keep this a safe place for all. It is important that you read it carefully before signing. Staff members are available to help you read and understand the language in all documents that you are asked to sign. You may ask them questions about anything that you do not fully understand. You are also welcome to take a copy of the lease to share with the people who give you advice. On the day that you sign your lease you should receive a copy of it. There may be additional terms and conditions with the lease. Make sure you get copies of those too. Please keep all of these documents carefully. Ask your case manager to get a special folder for these documents and put it in a safe place in your home. You may also ask your case manager to keep a copy of the lease and other documents in your supportive services file as an additional safe keeping option.

Your lease will need to be renewed by Click or tap here to enter text.. Lease renewal depends on you and your family being good tenants and good neighbors. You keep your promise to follow all rules, policies, contracts and agreements as well as house or community rules. It is our hope that you will make this your home for a long time. We do want you to know however that issues such as late or missed rent payments, damage to your apartment or to the building, or repeated conflicts with other tenants or staff may cause us to deny a lease renewal.

CREATING A SAFE PLACE – WHY HAVE RULES?

Why have rules at all? We try to have as few rules as we can.

The rules we have are to help everyone enjoy their own apartment space with as little interference by others in that enjoyment as possible, protect the all residents; and protect our building and its grounds; and. We also recognize that some people have periodic difficulties and we want to be a supportive, learning environment and want to give each resident a chance to learn to live in a nice apartment. As management, we will ty to balance the needs of everyone and ask that you please be patient as residents and their families work with us to become great members of our local apartment community. We believe that each of us is trying our best.

On the other hand, we will need to enforce our rules. We will not change those rules very often because that can be confusing. Please talk to us about ideas you have to make things safer and better.

Our Tenant Association Meetings are the place for new ideas and information sharing. See more about rules and the Tenant Association in Section 3 of this manual.

LEASE VIOLATIONS

Throughout this guide we have tried to highlight issues that may result in a lease violation. This means that you did not follow the rules you agreed to when you moved into your housing. We do not want to scare you, but we do want to make sure that you and your family know -- and can avoid -- issues that might cause us to end your lease. Unless there is a clear danger to other residents or to the building and community, we will strive to work with you to resolve lease violations. We need you to work with us though—if issues are not resolved they may result in your eviction from the building.

RENT PAYMENTS

Rent payments must Click or tap here to enter text.

Paying rent on time and regularly is very important. If you are having problems making your rent payment, please contact Click or tap here to enter text. as soon as possible. We want to help you figure out how to fix the problems that are getting in the way.

SECURITY DEPOSITS

We require a security deposit. A security deposit is money you give us now and we hold on to until you decide to leave the housing. It is money we use to repair any damage you cause to your apartment or pay rent you have not paid while living here. You will pay Click or tap here to enter text. . This money is not used to pay the rent for the last month you are living here. You still need to pay that rent. If you keep your promise to be a good tenant and a good neighbor, we will give this money back to you. We will only keep some of it if we need to pay for damages, excluding normal wear and tear.

You will get all or some of your money back when you have:

- Kept the promises you made in your lease
- Paid all rent
- Paid back any other money owed to [building management company]
- Left the apartment clean with no damage beyond normal wear and tear
- Removed all personal belongings from the apartment
- Inspected the apartment with the building superintendent or [property management] staff member and completed an inspection report.
- Returned all keys to the Program Director or building representative.

Remember we keep these funds only so that we can make sure that the next tenant moves into an apartment that is in as good condition as the one you are moving into now.

OCCUPANCY

One promise you make in the lease is about who will live in the apartment permanently. Only the family members named on your lease are allowed to occupy the apartment on a permanent basis. Having people residing in your apartment without authorization violates your lease agreement. The violation could mean you and your family could be evicted. Guests are allowed for up to Click or tap here to enter text. with specific approval by management. If you would like to change your lease to add one or more family members or need approval to have a guest stay beyond three days, please make an appointment to discuss this with the building manager.

PRACTICE NOTE

Tenant rights are state and even potentially local jurisdiction specific. The length of time a guest may reside in an apartment may be a zoning question or there may be a regulation that triggers when a person could establish residency without being on the lease. If you give a specific period, 3 days (72 hrs) or more, it would be good to have this rule reviewed against local regulations. In general the goal is to give families some flexibility as they may need to have relatives or supportive family friends stay to provide occasional support.

UTILITIES

You are responsible for the connection and payment of the following utility services:

- Click or tap here to enter text.

If you need assistance in obtaining these services, contact your Case Manager**.** Your case manager may also be able to connect you with some additional resources including:

Click or tap here to enter text.

[**link here to utility subsidy programs and/or tips from the utility on lowering bills**]

MOVE-IN

Your move-in day is a big day for us and you. We want you to get to know us.

Please let us know your move-in date and best guess about time of day. This will allow us to notify building staff so they can be alert and helpful. We want to help your move-in go as smoothly as possible. You can help us by:

- Being on time for your leasing appointment
- Bringing all required documents including:
  - Click or tap here to enter text.
- Asking questions if something is unclear to you
- Coming with questions you may have thought about ahead of time

PRACTICE NOTE

Our recommendation is that tenants are supplied with a folder at move-in to hold their signed lease, signed inspection form, copies of other relevant forms (e.g. complaint/ suggestion form, request for repair, etc.

Before you move in, we want to schedule an apartment walk through and inspection with you. The inspection is helps to protect you and us. The inspection form is at the end of this section, page___. During the inspection we will review the form together to make sure that everything in your apartment is in good shape and working order when you move in. This same form will be used when you move out to make sure that you are leaving the apartment the same way you found it. At the end of the inspection, we will ask you to sign the inspection form. The building staff who does the inspection with you will also sign the form. You will receive a copy of the signed inspection form and we recommend that you keep in your files with your lease.

- Your supportive housing case manager will visit you shortly after you move in. This visit is will help you get to know the case manager and how they can help you and your family. Please work with them to find a time when they can meet your whole family.

- We can also provide the following help and support during move-in:

  - Help child proofing for families with young children
  - Help connecting utilities.
  - Help getting furniture or other resources
  - Help identifying community resources to meet your needs

Please let us know if we can do anything else to be helpful in your move-in process.

KEYS MISPLACED OR LOST

We know that keys can get lost or misplaced. But it takes some time and costs us to replace the keys. This also might cause problems for you while you wait for new keys. Click or tap here to enter text. . Ask your case manager to help you have extra copies of your keys made. Find a safe place where you can keep the extra keys, but remember the keys are for you to use in emergencies not to give to visitors.

COMPLAINTS AND SUGGESTIONS

If you have any suggestions on how we might be able to improve our services to you, please do not hesitate to express yourself. We appreciate your feedback and welcome your ideas. A suggestion box is available in Click or tap here to enter text. . We have included an issue form at the end of this packet. Please let your case manager know if you want help in filling out this form.

Our tenants association can also be an important place to take ideas and talk with others about things that would improve the building or community. More information on our tenant association is included on Tenants Association: of this guide.

RESOLVING PROBLEMS

We want to create a safe, comfortable environment for every family living here. This means we want to address problems as early as possible. We want everyone involved to have an opportunity to get to a workable solution. We want everyone to understand on the process for dealing with problems.

- You can bring concerns or issues with another resident or with building staff to the attention of the property manager. Make an appointment to discuss the issue or fill out the ISSUE FORM.
- Issues with your case manager and or staff providing supportive services to your family should be addressed to Click or tap here to enter text. by making an appointment or filling out an issue form.

Please know that we will make every effort to keep your information confidential if desired.

It is our policy not to try to resolve issues when tempers are high. If you are having an active conflict with someone in the building, we will ask those involved to stand down and we will set a time to discuss the issue and develop solutions when everyone is calmer. This does not mean that we are not concerned about the issue and committed to getting things resolved.

If we or anyone in the building is having problems with the behavior of you or anyone in your family our commitment to you is that:

- We will try to communicate clearly with you about what the issue is.
- We will work with you around how to resolve the issue in a way that addresses everyone's concerns
- We will put everything in writing on an issue form
- If we think the concerns raised might result in termination of your lease or eviction from your apartment we will let you know this as soon as possible. so you can try to correct the issue before that happens.

PRACTICE NOTE

**Deferring efforts to deal with conflict is an important strategy when dealing with individuals with a history of trauma. They often have over active stress response systems. An extreme stress response can get in the way of an individual's ability to think through solutions and respond with moderation.

We know it is hard to be in conflict with others. Our goal is to work with you all to resolve issues and keep everyone in the building happy, healthy and safe. We encourage you to come to us with issues early so we can work together to prevent small problems from becoming big ones.

[**add in specific information on conflict resolution and mediation resources available to tenants**]

- Click or tap here to enter text.

SECTION 2: SUPPORTS AND RESOURCES

One of our goals is to connect you to the services you need to keep your family stable and on the pathway to success.

In this section we list some of the important supports and resources that you can draw on including:

- Program staff
- On-site services
- Services from partner agencies

In addition to these resources your supportive housing case manager can also help connect you to a wealth of other resources, supports and services available in the community. Please remember that while participation in services is not required they are often an important resource for your family's success. We encourage you to take advantage of what is offered, as well as support in identifying and accessing the services you need.

OUR PROGRAM STAFF

Staff Member	*What they can help you with*	*Contact Information*
Building Superintendent	Repairs to the building or your unit	

OUR PARTNERS

Agency	*What they can help you with*	*Contact Information*

OUR ON-SITE SERVICES

Service	*Details*	*How to Access*
	[Provide a short description of the service]	[Provide information on hours and other access details]

OFFICE HOURS

Click or tap here to enter text.

EMERGENCIES

The building superintendent should be contacted during non-office hours for the following types of situations emergencies only:

[**sample list--update with site specific information**]

- Plumbing Leaks or sewer stoppage that may endanger personnel or property.
- Any condition that might cause a fire
- Power outage or blackout
- Gas Leak
- Any other condition considered hazardous, such as broken windows, exposed wires, holes in ceiling or walls, etc.

Security personnel should be contacted immediately in the event of any of the following situations:

[**sample list--update with site specific information**]

- Physical violence or threats of physical violence
- Drug use by residents or their guests
- Theft or destruction of the property
- Small children left unsupervised in an apartment or area of the building
- Unauthorized or unknown strangers loitering or wandering around the building

Note: In situations involving medical assistance, criminal acts, physical injuries or violence in the building the resident property manager and/or security will call 911. They are not authorized to provide law enforcement or medical services. Tenants also have a responsibility to alert the resident property managers and Security and/or call 911 when the above situations become known to them.

Other Emergency Information:

General Emergencies: 911

Poison Control: Click or tap here to enter text.

Fire Department: Click or tap here to enter text.

Domestic violence services: Click or tap here to enter text.

Child Abuse and Neglect hotline: Click or tap here to enter text.

Mental health hotline: Click or tap here to enter text.

[Expand list to include crisis nursery or other available services]

It may be helpful for you to write these numbers on a piece of paper that you can tape to a kitchen cabinet.

[**Additional information you may add from your local fire department is a section on fire safety and the building's emergency evacuation plan**]

COMMON SPACES

The following common spaces are available for all:

[** replace with information for site

- ☐ For each space list:
  - Where it is located
  - Hours of use
  - Any process needed to get access
  - Any restrictions on who or how to use
  - Reiterated invitation to use
  - Examples are shown below

Community Room:

- The Community Room is for the enjoyment of all the families here There are rules for using the room:

1. No events may take place without permission of the Program Director.
2. You must request permission in writing least 7 days before the event.
3. Capacity is limited to 20 people
4. You must give a $20.00 Deposit to use the room. You will get all $20.00 returned if there is no damage and room is properly cleaned after use.
5. If the area has already been reserved, no two events can take place at the same time.
6. Events are not to be longer than five hours
7. Events must end by 9:00 pm on any given evening.
8. You are responsible for your guest(s) and any damage that may occur.
9. The room is to be cleaned once the event has ended.
10. If decorations are used they should be completely removed. No Alcoholic Beverages are allowed
11. Smoking is not allowed

Computer Lab and Library Rooms:

- These rooms are for the enjoyment and education of the tenants and their families. Tenant guests may also use these rooms if they are properly supervised. No tenant, family members or guests may occupy the space without staff supervision. Schedules will be posted regarding the day and times of availability. These schedules may change depending on staff availability as well as best time for tenant use.**]

SECTION 3: COMMUNITY RULES

The purpose of the community rules is to make sure a safe, clean supportive and peaceful environment for all families. All members of your family and any guests must comply with the community rules. Violation of community rules may be considered a breach of the promise you made in your lease agreement and could lead to your family's eviction.

VISITORS AND GUESTS

All visitors and guests, including children, sign-in and out when entering or leaving the building. Security Personnel cannot let visitors or guests into the building. You are responsible for identifying your guest using the intercom system and then using the buzzer system to allow them to enter the building only when you **are certain** you know who it is. If you have a guest who needs to get into your apartment while you are out, please contact the security desk. Tell the staff at the security desk the guest's name, the time you expect them and the time they will be leaving.

If you have a guest remaining in your home for a period of over Click or tap here to enter text. , you must inform the Click or tap here to enter text. in writing. Please tell the Click or tap here to enter text. the name of the person staying and how long you expect them to be staying. Failure to provide this information in writing is considered a violation of the promises you made in your lease agreement and you and your family may be evicted.

Please remember that you are responsible for your guests and their children and that your guests and their children must abide by the community rules while they are on the property. If behavior by your guests or their children violates house rules and/or causes damage to the property or discomfort to other residents or staff you will be asked to address the issue. If you cannot stop the behavior to stop you will be asked to limit visits by this guest or their children. We ask you to work with us on these issues. If there is a repeated pattern of damage or disturbance by your guests this could be a reason for lease termination

PRACTICE NOTE

**Tenant rights are state and even potentially local jurisdiction specific. The length of time a guest may reside in an apartment may be a zoning question or there may be a regulation that triggers when a person could establish residency without being on the lease. If you give a specific period, 3 days (72 hrs) or more, it would be good to have this rule reviewed against local regulations. In general the goal is to give families some flexibility as they may need to have relatives or supportive family friends stay to provide occasional support.

SMOKING

No one is allowed to smoke in any of the common areas. Tenants, guests, and staff may only smoke in their individual apartments or outside of the building. While it is your right to smoke in your unit we want to remind you that smoking has been shown to be harmful not only for you, but for your children. If you are going to be smoking in your unit we recommend that you keep the windows open and keep children's rooms and play areas smoke free.

CHILDREN

Our children are precious and we all want them to be safe and secure at all times.

Children under the age of Click or tap here to enter text. are never to be left alone in an apartment or the building. Children above Click or tap here to enter text. who are left alone should have a clear way of contacting a responsible adult in case of a crisis. Unfortunately building and program staff are not able to provide child care. If there is an emergency and your children will be left without care, please contact your case manager so they can help you problem solve. Leaving children unsupervised can lead to a child protective services report.

PRACTICE NOTE

**Check with local child welfare services to verify age at which a child may be left unsupervised. If not specified, we recommend 10

We have a number of resources for families with children including:

- Click or tap here to enter text.

The following space has been set aside for children's strollers and bicycles:

Click or tap here to enter text.

We ask that:

- You use a lock on your bicycle or stroller
- You do not store bicycles or strollers in other public areas or hallways
- If you store these items in your apartment, be careful of other people as you bring them down on elevators and stairways

As the parent you are responsible for your children's behavior. You are also responsible for the behavior of the children of any of your guests while in the building. If there are concerns with your child's behavior, we will discuss them with you first. We will work with you and your child to develop a solution plan.

Here is a list of issues that can cause problems among families and disrupt the building community. Please talk with your children and help to set limits about these things.

- Noise levels both within apartments and in common areas
- Graffiti or marking on the walls
- Leaving toys, bicycles or other equipment in pathways or common spaces
- Playing in common areas in ways that prevents others from accessing them, makes them feel unsafe, causes injury, or otherwise inconveniences.
- Conflict with other children in the building

OTHER

**Additions to this section might include rules for use of parking; acceptable and not acceptable spaces to "hang-out", restrictions on noise, etc. When adding these restrictions, it will be important to balance the need to create a safe, supportive community for all families with the reality that kids cannot always be expected to be quiet and still. Setting aside designated spaces for children to play and "hang-out" can proactively address the problems that sometimes arise when they play and hang-out in inappropriate spaces.

SECTION 4: OPPORTUNITIES TO GET INVOLVED

Tenants Association:

The tenants association is a group of tenants in the building who have volunteered to work actively to improve the quality of life. The tenants association provides a way for the tenants to communicate with the staff and management as well as an opportunity to get involved in building a stronger community for all residents. If you wish to be a part of this group, see the Program Director for further information.

[**Replace below with details on the specific process used for this site**]

The tenants association meets with the Program Director every 4-6 weeks. It then meets with the tenants of the building within 1-2 weeks of that meeting. A variety of things are discussed. Most of the discussion is about how to make this the best place to live. This process is on-going and notices and flyers are given to all tenants to keep them informed and remind them when these meetings are held.

SECTION 5: MAINTAINING A HEALTHY AND SAFE HOME

CHILD PROOFING

It is important to make sure that your home is a safe place for your child. Before you moved in, we did the following things to make your home a safe place for kids:

- ✓ We set water faucet temperatures so children cannot be scalded.
- ✓ We made sure that blinds or window treatments are cordless.
- ✓ We installed window guards.

There is still more to do. As part of your welcome visit, your supportive housing case manager will help you do a home safety assessment. Depending on the age of your child or children, the case manager will help you:

[**We recommend that sites support families with the following—adapt guide to list actual supports provided**]

1. Install locks on cabinets or drawers containing hazardous materials such as poisonous materials, cleaning supplies, medicines, sharp knives or tools.
2. Make sure that the sleeping area for your child is safe:
    - Infant cribs meet safety standards
    - Crib space does not have smothering hazards
    - Bunk beds have safety rails and children under 6 do not use the upper bunk.
3. For infants and toddlers:
    - Install door stops to ensure doors don't slam on little fingers.
    - Set up gates and other barriers to prevent young children from getting into unsafe spaces.
    - Make sure electrical outlets are covered
    - Anchor bookshelves and other tall furniture so it will not topple if climbed.
    - Install bumpers or pads on furniture with sharp corner

CHILD ABUSE AND NEGLECT

We all want our children to be safe from any kind of abuse or neglect. If you are struggling with parenting stress, reach out to your supportive services case manager or friend or family member for support. We all have moments when we struggle to control anger, to have the energy to make dinner or give baths, or to provide the nurturing care we want to. Asking for help in these moments is a sign of strength.

The supportive services staff is available at all times if you are feeling stressed and need support. You can also call a trusted neighbor or friend to support you if you need some time to cool down. Your case manager will also work with you to help develop a list of supporters to call when you need extra help.

Our staff are required to report to child protective services if they suspect child abuse or neglect. Child protective services will decide if an investigation is needed. It is our goal not to make these calls, therefore:

PRACTICE NOTE

All staff should:

- Be aware of the signs and symptoms of child abuse and neglect
- Understand internal protocols of who to go to when they have concerns of possible CAN
- Understand how to make a report if they feel that a child is immediate risk of harm

- If one of our staff members observes something that causes us to have concerns—but we don't have any immediate worries that your child is unsafe—we will make sure to discuss these concerns with you. We want to make sure you know about any behavior that could make your child unsafe. We want you to have an opportunity to address the concern before we feel a report needs to be made.

- Please talk to your case manager right away if you feel like stress, depression, or other issues are making hard for you to parent. We want to help you to problem solve around these tough times and find solutions that will make sure that you and your kids thrive.

- If you have concerns about another adult who is in your child's life, please let us know. We can support you in making a plan to keep your kids safe.

Whenever we feel that a situation is putting a child in danger we will need to make a child welfare report. If the concern is something that we are required to report, we do not want you surprised by a CPS response. We will make every attempt to talk with you first. We would like you to be present when we make the call so that you are fully informed about the process.

DOMESTIC VIOLENCE

If you are or have been in a relationship with a partner who is or has threatened you with physical, sexual or emotional violence we want to support you in keeping yourself and

PRACTICE NOTE

Jurisdictions have different policies and regulations for addressing property damage caused by an abusive partner and lock changes should the victim partner stay in housing and the other partner moves out.

Please check your local regulations before determining what guidance you can provide to your tenants.

These situations my result in lease bifurcation. The Violence Against Women Act of 2013 gives landlords and Public Housing Authorities the ability to bifurcate a lease to maintain the victim's tenancy while evicting the perpetrator and to use certification documents in eviction cases.

your family safe. We are here to help you to stay safe regardless of your decision to leave or stay in the relationship. Here's how we are prepared to help:

- Do not hesitate to call 911 if you are in danger. We want you to seek help from 911 if you need it and your housing will not be jeopardized for multiple calls for help.

- Your case manager is best able to help you if you are willing to talk to them about current or past abuse. They can help connect you to an advocate who understands what you are going through, can speak with you confidentially about your situation, and help you decide what to do (see earlier list of Emergency Response resources, page Emergencies)

- If you have been threatened or are afraid that your current or former partner will harm you or your children, please talk with your case manager or the resident property manager as soon as possible. They will help you develop a plan to keep you and your children safe.

- If you have an order of protection in place, please let us know so we can get a copy to have on record. Staff will talk with you about what you want us to do if we see that person present on the property. It would help staff to identify that person if you could also provide us with a photograph of that person.

- This building is private property and staff have the authority to turn away unwelcome guests. Please let us know if there is anyone else who has threatened or harmed you and/or your children in the past that you do not want in the building, even if a formal order of protection is not in place.

BULLYING

We take seriously our responsibility for keeping all children safe and view bullying or violence between children as a very serious problem. If you believe your child is being bullied or is in regular conflict with another child in the community, we urge you to talk with your case manager.

MAINTAINING A CLEAN HOME AND COMMUNITY

Your Home

Your home is your own space. Keeping it clean is important to your family's health and for all of us in the community. We understand that chores required to keep a house clean can be overwhelming. We are here to help.

First, we suggest these some simple things you could do as a family and with your case manager:

- ✓ Get rid of extra clutter to make it easier to clean.
- ✓ Ask family members to take off their shoes when entering your home to reduce dirt and dust.
- ✓ Keep pets away from sleeping areas and especially off the beds.

- ✓ Keep a cleaning schedule that includes vacuuming. Your case manager can help you create a cleaning schedule with specific roles for each family member.

Our policy is to do a home inspection every Click or tap here to enter text. during this time our staff can talk with you about home upkeep issues that you are struggling with and help you strategize.

[**Sample list below, update with site specific rules which emphasize upkeep but still provide opportunities for tenants to feel that they can individualize their home**]

In addition, the following rules about the upkeep of your apartment are meant to make sure your apartment and building are safe and healthy places for your family and everyone living in this building:

- Appropriate window covering such as shades or curtains can be used in addition to the furnished shades. Please do not remove the pre-installed shades. Please do not use sheets, blankets, heavy paper or other such items as window coverings.
- No signs, ads, notices or other lettering should be taped or painted on any part of the outside or inside of the apartment or building (including your apartment door). Holiday decorations are allowed.
- Do not store or place things on your window sills. We do not want objects falling from your windows.
- Do not sweep or throw dirt or objects from your apartment into the hallways or stairways. This makes the building less healthy and nice for you and your neighbors.
- Kitchens often require special care. Wipe your kitchen counter tops promptly after you have prepared a meal. This helps prevent staining. Also, use a cutting board when preparing meals so that you do not cut into the counter tops
- Special care should be given to the hardwood floors in your apartment. You should mop the wood floors with a damp mop.
- The sewer system connected to the toilet can handle all normal drainage. But there are somethings that it cannot handle:
    - Paper towels, disposable diapers, sanitary napkins, and other bulky material should not be put in toilets.
    - Care must be taken to avoid accidently losing combs, jewelry and other items down the toilet. All of these things could may cause the toilet to be clogged.
    - Kitchen grease should not be poured into toilets. It should be poured into a container like an empty soup can and thrown away after cooling with the garbage in the proper receptacle outside in the garbage area.

Garbage Disposal

[**Fill in below with appropriate information including:**]

- Location
- Pick-up dates and approximate times
- Limits on amount or kinds of garbage accepted—if any
- Guidance on sorting if recycling and/or composting are available in addition to garbage
- How garbage should be contained
- What to do with bulk items

COMMON SPACES

Common spaces are for the enjoyment of all families. We hope that you will join us in keeping them clean and making them welcoming and enjoyable spaces for all.

Do's	***Don't's***
- *Make our community beautiful!*	- *Graffiti: Please do not leave graffiti on the property*

- *Please come with your ideas for making the common spaces more beautiful and welcoming. We are happy to support community members in making the whole community feel like a home and community for all.*

- *Please play your part in picking-up and putting things back—even if the mess is not your own.*

- *Litter: Please do not throw litter or garbage anywhere other than designated garbage containers.*

- *Personal Property: Please do not leave personal property lying in the hallways or common areas.*

If you or a member of your family is responsible for vandalism, defacing, or destruction of common property you may be liable for the costs of repair. If you see others violating these rules please let the property manager know so they can have a discussion with that tenant.

PESTS

Nobody likes to have pests. They can spread disease, ruin your things, and contaminate food. Living in a building with others it is important to get on top of pest problems as soon as possible. You can help deal with pests before they become a problem by:

☐ Removing pests' access to food, water and shelter by cleaning regularly.

☐ Sealing cracks and openings in your home and make sure all windows have screens. If you are missing screens or they need repair tell [property management]

☐ Storing food in pest-resistant containers and keep pet food stored and off the floor.

☐ Using trash cans with tight well-fitting lids, especially in the kitchen

☐ Taking out trash and vacuum frequently

☐ Eliminating dripping or standing water. You can ask [property management] for help.

☐ Taking care of clutter. Clutter can create places for pests to hide.

☐ Avoiding poisonous pesticides which can be harmful for you and your children. Use safe alternatives, such as sticky traps or sealed bait traps.

If you see roaches, rodents, bedbugs, or other pests in your apartment or any common area please contact the building manager as soon as possible. We will try to have the problem addressed. If we need to bring in pest control to take care of the issue, we may need to get access to your apartment and may ask you to prepare the apartment so they can easily get access to the spaces they need.

ADDITIONAL RESOURCES

Click or tap here to enter text.

INSPECTION FORM

This inspection form helps us to make sure that the apartment is in good shape for you and your family when you move in. As we go through the inspection we will note any problem areas and either flag for repair or note the issue.

We will use the same form at move out to make sure that you are leaving it in good shape for the next family to move in. Maintaining your apartment and leaving it in good shape are important parts of being a good tenant and will be important for getting your security deposit back. You will not be responsible for any issues which we noted in the initial inspection that have not been addressed.

Kitchen	*Bathroom*
☐Fridge working	☐ Toilet working
☐ Fridge clean	☐ Toilet clean
☐ Stove working	☐ Sink working
☐ Stove clean	☐ Sink clean
☐ Floor clean	☐ Tub working
☐ Cabinets clean	☐ Tub/shower area clean
	☐ Floor clean

General

☐ Floors: _____

☐ Walls: _____

☐ Window treatments: _____

☐ Light Fixtures: _____

☐ Doors: _____

☐ Windows: _____

☐ Free of litter: _____

☐ Smoke detectors functioning: _____

Included Furniture:

_____

_____

_____

_____

ISSUE FORM

This form helps us to address issues that are becoming a problem for our tenants. Please feel free to fill it out anonymously or to give us your name:

_____

Either way we will make our best effort to look into the issue raised and to address it. If you want to give us your name, we are happy to give you a report on what our final plan for addressing the issue was. You can also make an appointment with the property manager to talk about the issue.

1. Please describe the issue that needs to be resolved: _____-
   _____
   _____
   _____
   _____
   _____

2. Describe specific times when this issue has come up (list dates and who was involved):
   _____
   _____
   _____
   _____
   _____
   _____

3. What are your ideas for resolving this issue? _____-
   _____
   _____
   _____
   _____
   _____

Tips: Searching for a Unit

About this tip sheet: Teams may use this telephone guide to support families when calling prospective landlords. Review the guide before making calls and be prepared to answer questions that may arise during the discussion.

Remind parents the importance of showing up on time to view an apartment and providing notification if they cannot keep an appointment. Also, remind families they should confirm whether the landlord will call them back with a decision or if they follow up with the landlord.

Note: If teams find that many parents do not have a reliable contact number (e.g., if they are staying at a shelter), consider arranging a voicemail system that parents can access remotely.

Directions: This tip sheet is designed to help determine whether an apartment would be appropriate. The questions about screening are important because many landlords charge an application fee to screen for criminal history, credit history, and rental history. The more you know in advance about the "tolerance level" of the landlord, you can best decide whether to move forward with the application process.

TIPS TO HELP YOU WITH THE CALL

- If possible, call from a quiet place so you can hear the landlord. It is also better if the landlord does not hear a lot of noise (like people yelling) in the background.
- Review the list of questions below so you are prepared when you call the landlord.
- Know when you can move (i.e. the date the unit is available).
- Write down the name of the person you talked to, his or her phone number, and the date you made the call, in case you need to call back to ask more questions or to reschedule an appointment.
- Since you may have to contact several landlords to find an apartment, use the "Housing Search Tracking Worksheet" to help you remember when you have scheduled an appointment to look at an apartment, where you have submitted applications, and when and with whom you need to follow up about an apartment.

TELEPHONE SCRIPT

"Hello, my name is _____. I'm looking for a (1,2,3,4,5) bedroom apartment for (this month, next month, two months from now). Do you have any available units?"

If the landlord does not have any available units: "Do you have any other properties with a vacancy?"

If the landlord does have a vacancy, ask the following questions. Be sure to write down the answers. If the landlord has two or more apartments, write down the answers for each unit.

Date of Call: _____

Table 1: Questions About the Apartment		
	Apartment 1	**Apartment 2**
What is the address of the property?		
What date is the unit available?		
Do you charge an application fee? *If he/she says yes*: How much?		
What is the monthly rent?		
How much is the security deposit?		
What utilities would I pay?		
Do you know approximately how much utilities for that unit cost each month?		
How many people are allowed to live in the unit?		
What is the minimum lease you require (how many months)?		
Do you require me to have a certain income to rent the unit? *If he/she says yes:* How much?		
Are there laundry facilities on-site? *If he/she says no:* Is there a laundromat nearby?		
Is the apartment near the subway or a bus line? Which one?		

Table 2: Screening Questions *[Ask only those questions that apply to your situation.]*		
	Apartment 1	**Apartment 2**
If you've had credit problems: Do you work with people who have had credit problems in the past?		
If you've had a previous eviction: Do you work with people who have evictions that can be explained?		
If you have a disability: Can you accommodate people with disabilities?		
If you have pets: What are your rules about pets?		

The landlord may ask you to explain the circumstances if you have bad credit, a criminal history, or prior evictions. They may want to know dates, places, and if you owe any money. The best response is to be truthful. You may want to write some notes about your circumstances below to make sure you are prepared to answer the landlord's questions.

_____

_____

_____

_____

_____

_____

Here are things that might show a landlord how you are improving your life:

___ *employed for* ___ *months/years*
___ *going to school (or job training)*
___ *working with a credit counselor*
___ *learning how to be a better tenant*
___ *learning money management skills*
___ *being connected to supports in the community*
___ *paying off money you owe*

If the landlord is willing to work with you:

- Is it possible to set up a time to see the apartment? When? _____
- Can you give me directions from *[where you are living/staying]?* _____

_____

_____

_____

_____

- Can I have your name again, in case I need to call you back? _____
- And what is the best number to reach you at? _____

Be sure to thank him or her before hanging up.

Table 3: Follow-Up Housing Search Tracking Worksheet		
	Apartment 1	**Apartment 2**
Apartment address		
Date and time of appointment		
Did you fill out an application? *If yes, when will the landlord be contacting you with a decision?*		
Did you get the apartment? *If yes, when is the move-in date?* *If no, what was the reason provided?*		

KFT TIPS
Securing and Maintaining KFT Housing

- **Keeping Families Together is a Partnership.** Maintaining housing stability takes ongoing partnership that includes: the parent, KFT Provider team, along with formal (State agencies like DCA, DCF etc.) and informal partners. Everyone has a role to play in maintaining safe and stable housing in partnership with KFT families. This tip-sheet highlights factors that may increase family success in stable maintaining housing share common pitfalls that need to be avoided where possible.

- Carefully review and follow all requirements written in the lease and housing voucher agreement. This also includes getting everything in writing, especially any lease changes.

- Communicate regularly with housing partners. Housing partners include landlord and/or property management, the DCA local team and the KFT Provider team. This includes asking questions early and often to clarify information and connect to help when needed.

- Purchase renters' insurance. Since the landlord's insurance policy will not cover the renter's losses due to theft or damage. Renters' insurance provides crucial coverage in the event of loss or damage, for a relatively low monthly cost.

Common Pitfalls

- Violations of the Lease agreement.
- Violations of the rules and regulations of the housing voucher. (i.e. DCA voucher rules and regulations)
- Delays in Communication with partners (this may include the landlord and/or property management, DCA local team, the KFT Provider team and the DCP&P team, *when applicable*). This also includes making sure that partners have a clear way to connect with the family (i.e. a working phone number, email etc.).

Keeping Families Together (KFT)

New Jersey Department of Children and Families

From Program Launch to Move-In

KFT Program Launch

Office of Housing (OOH) sends the Screening Tool and Memo to the KFT Lead at the DCP&P local office.

KFT Lead returns the completes the screening tool to OOH.

OOH collaborates with the KFT Lead to resolve data quality issues ahead of finalizing the list.

OOH screens the family list to confirm eligibility.

OOH provides a randomized list of families to the KFT provider and the KFT Lead in the DCP&P local office.

2 weeks

1 week

KFT Provider schedules case conferences with the DCP&P team (KFT lead, DCP&P case worker, and DCP&P supervisor etc.).

Case Conferences occur between the KFT Provider and DCP&P team (KFT lead, DCP&P case worker, and DCP&P supervisor).

Case conferences continue to occur until all families on the list have been conferenced. *The list may change at this time as some families may no longer be eligible. *

2 weeks

Post conference KFT Provider initiates contact with eligible families to schedule the Intake/Enrollment meeting.

KFT Provider, DCP&P worker, and the family meet for the Intake/Enrollment meeting, where KFT is discussed with the family. If the family agrees to KFT services, the DCA application process begins. A follow-up meeting is scheduled to continue the application process.

Follow-up meetings continue to occur until all documents are gathered and the application is submitted.

KFT Provider, DCP&P team, and the family collaborate to complete the DCA application and gather required supporting documents for all family members. Examples of supporting documents include:

- Social Security Cards
- Birth Certificates
- State-issued ID (18yrs and older)
- Proof of income (18yrs and older)
- Supporting letter for any household member with criminal charges.

Submit complete voucher application to DCA.

DCA will notify the KFT Provider if the application is incomplete (i.e., missing documentation, unclear criminal background checks or if more information is needed.

DCA reviews application packet for eligibility and completes background checks for adult household members.

45 Days if application is complete and additional information is not needed.

KFT Provider and family meet with DCA Field Representative, upon approval at the voucher Briefing Meeting.

KFT Provider assists the family with identifying a unit in the community.

Up to 150 days with approved extension

Once a unit is identified, a Request for Tenancy Approval (RFTA) is submitted to the DCA Field Office.

1 week

If the unit fails inspection, the landlord is provided with a list of deficiencies and given 30 days to abate.

DCA conducts a Housing Quality Standards (HQS) Inspection of the unit.

A Housing Assistance Payment (HAP) contract is executed between DCA and the landlord; a lease is executed between the landlord and tenant.

Move-In

KFT Flowchart 1/12/2022

Housing Choice Voucher Program

General Lease-Up Process for Landlords, Public Housing Authorities (PHAs) and Tenants

Tenant	Landlord of Unit	PHA
Applies for and Receives Voucher from PHA	Markets Unit	Screens Applicants for HCV Eligibility
Selects Unit (or may re-lease current unit)	Screens Tenants for Suitability and Selects Tenants	Provides Voucher to Tenant
Tenant and Landlord Complete RFTA[1]		Reviews RFTA[1]
	Accepts Rent Offer	Determines Rent Reasonableness[2]
	Unit Complies with PHA Inspection[3] Rules	Schedules and Completes Inspection[3]
Tenant and Landlord Execute Lease	Landlord and PHA Execute HAP[4] Contract	Receives Executed Agreements
Moves In and Pays Security Deposit	Receives HAP[4] and Rent	Sends Monthly HAP[4]
Pays Monthly Tenant Rent and Utilities	Manages Property and Enforces Lease	Schedules and Completes Re-inspection[3]
Complies with Lease and Reports Issues to Landlord	Unit Complies with Re-inspection[3]	Determines Rent Reasonableness[2] (if rent increase)
Renews Lease	Renewal *(can be automatic)* or Send Rent Increase 60 Days Prior to End of Lease Term	

Endnotes

[1] Request for Tenancy Approval (RFTA): Before approving the assisted tenancy and executing the Housing Assistance Payments (HAP) contract, the PHA must ensure that the following program requirements have been met:

- The unit is eligible;
- The unit has been inspected by the PHA and meets Housing Quality Standards (HQS);
- The lease includes the tenancy addendum;
- The rent charged by owner is reasonable; and
- For families receiving HCV program assistance for the first time, and where the gross rent of the unit exceeds the applicable payment standard for the family, the PHA must ensure that the family share does not exceed 40 percent of adjusted monthly income. This cap is referred to as the maximum family share (24 CFR 982.508).

In addition, the PHA must not approve:

- If the PHA has been informed (by HUD or otherwise) that the owner is debarred, suspended, or subject to a limited denial of participation under 2 CFR part 2424.
- If the owner is the parent, child, grandparent, grandchild, sister, or brother of any member of the family, unless the PHA determines that approving the unit would provide reasonable accommodation for a family member who is a person with disabilities. This restriction against PHA approval of a unit only applies at the time a family initially receives tenant-based assistance for occupancy of a particular unit, but does not apply to PHA approval of a new tenancy with continued tenant-based assistance in the same unit.
- Other reasons as defined in 24 CFR 982.306.

[2] Rent Reasonableness: HUD regulation 24 CFR 982.507 requires that PHAs perform a rent reasonableness determination before executing a HAP contract and before any increase in rent. The PHA must determine that the proposed rent is reasonable compared to similar units in the marketplace and not higher than those paid by unassisted tenants on the premises.

[3] Inspections: PHA must inspect the unit leased to a family prior to the initial of the lease, at least biennially during assisted occupancy (triennially for rural PHAs), and at other times as needed, to determine if the unit meets the HQS.

Some, but not all, PHAs have additional flexibility to approve tenancy and begin paying HAP on a unit that fails to meet the HQS, provided the deficiencies are not life-threatening and/or to approve assisted tenancy of a unit before the PHA conducts the initial HQS inspection if the property has, in the previous 24 months, passed a qualifying alternative inspection. For more information on these provisions see PIH Notice 2017-20.

[4] Housing Assistance Payment (HAP): is the monthly assistance payment by a PHA, which is defined in 24 CFR 982.4 to include: (1) A payment to the owner for rent to the owner under the family's lease; and (2) An additional payment to the family if the total assistance payment exceeds the rent to owner.

The HAP contract is the housing assistance payments contract between the owner and the PHA.

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Keeping Families Together - Baseline Data Collection Survey

Baseline Family Survey

Overview and Purpose: The following survey is used by the New Jersey Department of Children and Families' Office of Strategic Development to collect baseline data about families participating in the Keeping Families Together (KFT) pilot program. This survey, which is completed by the KFT grantees, provides a snapshot of families as they enter the KFT program and includes information about family demographics, housing status, and other co-occurring and/or service needs.

Survey Instructions: Please complete a survey for each family who has ever been enrolled in your KFT program. For new families entering the program, the survey must be completed within 30 days of enrollment. For existing families and families who have been discharged, please use your available records and documentation to answer these questions based on the family's status upon enrollment in the program.

Questions or concerns should be directed to the Office of Strategic Development by contacting:

Kerry-Anne Henry
KerryAnne.Henry@dcf.nj.gov
609-888-7204

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

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Family Identifiers

*** 1. DCP&P Case ID #:**

*** 2. Please select the mother's birth year. If there is not a mother in this household, please choose the primary caregiver's birth year and use the comments section to describe who the primary caregiver is (e.g., father).**

Comments

*** 3. Please provide the date when the family was enrolled in your KFT program.**

Date of Enrollment

Date

MM/DD/YYYY

*** 4. At the time of enrollment in KFT, which CP&P Local Office was assigned to the family's case?**

- Atlantic East
- Atlantic West
- Bergen Central
- Bergen South
- Burlington East
- Burlington West
- Camden Central
- Camden East
- Camden North
- Camden South
- Cape May
- Cumberland East
- Cumberland West
- Essex Central
- Essex North
- Essex South
- Newark Center City
- Newark Northeast
- Newark South

- ( ) Gloucester East
- ( ) Gloucester West
- ( ) Hudson Central
- ( ) Hudson North
- ( ) Hudson South
- ( ) Hudson West
- ( ) Hunterdon
- ( ) Mercer North
- ( ) Mercer South
- ( ) Middlesex Central
- ( ) Middlesex Coastal
- ( ) Middlesex West
- ( ) Monmouth North
- ( ) Monmouth South
- ( ) Morris East
- ( ) Morris West
- ( ) Ocean North
- ( ) Ocean South
- ( ) Passaic Central
- ( ) Passaic North
- ( ) Salem
- ( ) Somerset
- ( ) Sussex
- ( ) Union Central
- ( ) Union North
- ( ) Union West
- ( ) Warren
- ( ) Unknown
- ( ) Other (please specify)

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Housing Status

*** 5. Please choose the answer that best describes the family's housing situation upon enrollment in KFT.**

- ( ) Homeless (e.g., living on street, in car, etc.)
- ( ) Residing in shelters and/or transitional housing
- ( ) Enrolled in and/or exiting residential treatment facility (mental health or substance abuse)
- ( ) Living with friends or family (e.g., "couch surfing")
- ( ) At risk of losing permanent housing (e.g., eviction)
- ( ) Moved 2 or more times in past 12 months
- ( ) Other (please comment)
- ( ) Unknown

Comments:

*** 6. How long has this family been experiencing homelessness or housing instability? Homelessness/housing instability is defined as experiencing one or more of the situations listed in Question 4. Please choose the answer that best represents the total length of time this family has spent in one or more of those situations.**

- ( ) 0-6 months
- ( ) 7-11 months
- ( ) 1-2 years
- ( ) 3-5 years
- ( ) 6-10 years
- ( ) 11+ years
- ( ) Unknown

Comments:

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Income & Benefits

*** 7. What is the family's gross annual household income at the time of enrollment? This amount shall include the total income earned by all members of the household prior to any taxes or deductions. If you are unable to provide an exact amount, please estimate as closely as possible. If you do not have any income-related information, please write unknown.**

*** 8. What are the family's source(s) of income upon enrollment in KFT? Please check all that apply.**

- [ ] Employment
- [ ] Unemployment Benefits (UI)
- [ ] Temporary Assistance (TANF/GA)
- [ ] Supplemental Security Income (SSI; adult and/or child)
- [ ] Disability Benefits (SSDI)
- [ ] Social Security Benefits (other than SSI or SSDI)
- [ ] Child Support Payments
- [ ] Alimony
- [ ] Recurring Gifts or Informal Support from Family/Friends
- [ ] Unknown
- [ ] Other (please specify)

*** 9. Which, if any, of the following is the family receiving upon enrollment? Please check all that apply.**

- [ ] SNAP/Food Stamps
- [ ] Medicaid (State Health Insurance)
- [ ] Head Start/Early Head Start Services
- [ ] Earned Income Tax Credit
- [ ] Women, Infants, and Children Program (WIC)
- [ ] Unknown
- [ ] Other (please specify)

*** 10. At the time of enrollment, did the family have any outstanding utility bills?**

- ( ) Yes
- ( ) No
- ( ) Unknown

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Parent Characteristics & Household Composition

If this family is a two-parent household, please assign one parent as "Parent 1" and the other parent as "Parent 2." It does not matter which parent is assigned as Parent 1 or Parent 2.

You will begin with questions about Parent 1. For questions 11-21, respond with the answer(s) that best reflect Parent 1 at the time of enrollment.

*** 11. DCP&P Person ID # for Parent 1:**

*** 12. What is the gender of Parent 1?**

- ( ) Male
- ( ) Female
- ( ) Unknown

*** 13. Please select Parent 1's birth year.**

*** 14. What is the age of Parent 1 at the time of enrollment?**

- ( ) 18-24 years old
- ( ) 25-34 years old
- ( ) 35-44 years old
- ( ) 45-54 years old
- ( ) 55-64 years old
- ( ) 65+ years old
- ( ) Unknown

*** 15. What is the race/ethnicity of Parent 1? Check all that apply.**

- [ ] African American
- [ ] White (Non Hispanic/European American)
- [ ] Hispanic or Latino
- [ ] Native American or Alaskan Native
- [ ] Asian
- [ ] Native Hawaiian/Pacific Islanders
- [ ] African Nationals/Caribbean Islanders
- [ ] Middle Eastern
- [ ] Multi-racial
- [ ] Unknown
- [ ] Other (please specify)

*** 16. What is the marital status of Parent 1 upon enrollment in KFT?**

- ( ) Single
- ( ) Married
- ( ) Partnered
- ( ) Widowed
- ( ) Divorced
- ( ) Separated
- ( ) Unknown

*** 17. What is the highest level of education completed by Parent 1 at the time of enrollment?**

- ( ) Elementary or junior high school
- ( ) Some high school
- ( ) High school diploma or GED
- ( ) Trade/Vocational Training
- ( ) Some college
- ( ) 2-year college degree (Associate's)
- ( ) 4-year college degree (Bachelor's)
- ( ) Master's or higher
- ( ) PhD or other advanced degree
- ( ) Unknown

*** 18. What is the employment status of Parent 1 at the time of enrollment?**

- ( ) Employed (working full-time, part-time, per diem, etc.)
- ( ) Self-employed
- ( ) Not employed, Looking for work
- ( ) Not employed, Not looking for work
- ( ) Unable to Work (please comment)
- ( ) Enrolled in School/Vocational Program (full-time, part-time, certificate program etc.)
- ( ) Other (please specify)
- ( ) Unknown

Comments

*** 19. Which, if any, of the following is Parent 1 experiencing upon enrollment in KFT? Please check all that apply.**

- [ ] Mental Health Diagnosis/Disorder
- [ ] Substance Use Disorder
- [ ] Chronic Medical Condition
- [ ] Domestic Violence
- [ ] Unknown
- [ ] Other (please specify)

*** 20. Which, if any, of the following has Parent 1 experienced prior to enrollment in KFT? Please check all that apply.**

- [ ] History of Mental Health Diagnosis/Disorder(s)
- [ ] History of Substance Use Disorder(s)
- [ ] History of Domestic Violence
- [ ] History of Child Welfare Involvement as Child
- [ ] Chronic Medical Condition
- [ ] Other History of Trauma
- [ ] Criminal History
- [ ] Unknown
- [ ] Other (please specify)

*** 21. Does Parent 1 have health insurance coverage upon enrollment in KFT?**

- ( ) Yes
- ( ) No
- ( ) Unknown

*** 22. Please choose the response that best describes the household composition upon enrollment in KFT.**

- ( ) One-Parent Household
- ( ) Two-Parent Household
- ( ) One-Parent Household with Other Non-Parent Adult (e.g., paramour, grandmother, aunt, cousin, friend etc.)

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Parent Characteristics & Household Composition (continued)

Because you indicated this is a two-parent household in Question 22, you will now begin answering questions about the second parent in the household ("Parent 2"). For questions 23-33, please respond with the answer(s) that best reflect Parent 2 at the time of enrollment.

*** 23. DCP&P Person ID # for Parent 2:**

*** 24. What is the gender of Parent 2?**

- ○ Male
- ○ Female
- ○ Unknown

*** 25. Please select Parent 2's birth year.**

*** 26. What is the age of Parent 2 at the time of enrollment?**

- ○ 18-24 years old
- ○ 25-34 years old
- ○ 35-44 years old
- ○ 45-54 years old
- ○ 55-64 years old
- ○ 65+ years old
- ○ Unknown

*** 27. What is the race/ethnicity of Parent 2? Check all that apply.**

- ☐ African American
- ☐ White (Non Hispanic/European American)
- ☐ Hispanic or Latino
- ☐ Native American or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islanders
- ☐ African Nationals/Caribbean Islanders
- ☐ Middle Eastern
- ☐ Multi-racial
- ☐ Unknown
- ☐ Other (please specify)

*** 28. What is the marital status of Parent 2 upon enrollment in KFT?**

- ( ) Single
- ( ) Married
- ( ) Partnered
- ( ) Widowed
- ( ) Divorced
- ( ) Separated
- ( ) Unknown

*** 29. What is the highest level of education completed by Parent 2 at the time of enrollment?**

- ( ) Elementary or junior high school
- ( ) Some high school
- ( ) High school diploma or GED
- ( ) Trade/Vocational Training
- ( ) Some college
- ( ) 2-year college degree (Associate's)
- ( ) 4-year college degree (Bachelor's)
- ( ) Master's or higher
- ( ) PhD or other advanced degree
- ( ) Unknown

*** 30. What is the employment status of Parent 2 at the time of enrollment?**

- ( ) Employed (working full-time, part-time, per diem, etc.)
- ( ) Self-employed
- ( ) Not employed, Looking for work
- ( ) Not employed, Not looking for work
- ( ) Unable to Work (please comment)
- ( ) Enrolled in School/Vocational Program (full-time, part-time, certificate program etc.)
- ( ) Other (please specify)
- ( ) Unknown

Comments

*** 31. Which, if any, of the following is Parent 2 experiencing upon enrollment in KFT? Please check all that apply.**

- [ ] Mental Health Diagnosis/Disorder
- [ ] Substance Use Disorder
- [ ] Chronic Medical Condition
- [ ] Domestic Violence
- [ ] Unknown
- [ ] Other (please specify)

*** 32. Which, if any, of the following has Parent 2 experienced prior to enrollment in KFT? Please check all that apply.**

- [ ] History of Mental Health Diagnosis/Disorder(s)
- [ ] History of Substance Use Disorder(s)
- [ ] History of Domestic Violence
- [ ] History of Child Welfare Involvement as Child
- [ ] Chronic Medical Condition
- [ ] Other History of Trauma
- [ ] Criminal History
- [ ] Unknown
- [ ] Other (please specify)

*** 33. Does Parent 2 have health insurance coverage upon enrollment in KFT?**

- ( ) Yes
- ( ) No
- ( ) Unknown

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Child Characteristics

The questions in this section pertain to ALL child(ren) who will be residing in the household and in the care/custody of the parent(s). This includes children who have not yet been reunified with their parent(s).

*** 34. Please provide the following information for each child who will be residing in the household. Answers should reflect the child's status upon their family's enrollment in KFT. This questions consists of multiple columns - please use the scroll bar to complete all nine components of this question for each child.**

	Gender	Age	CP&P Case Goal	Health Insurance	Pediatrician
Child 1					
Child 2					
Child 3					
Child 4					
Child 5					
Child 6					
Child 7					
Child 8					
Child 9					
Child 10					

*** 35. Are any of the child(ren) involved with juvenile justice upon the family's enrollment in KFT?**

- Yes
- No
- Unknown

*** 36. Do any of the child(ren) have a suspected or confirmed substance use disorder upon the family's enrollment in KFT?**

- Yes
- No
- Unknown

Once you click "Done" at the bottom of this page, you will have completed the survey for this family. You will be automatically looped back to the start of the survey. If you have additional families, you can continue with your next family.

If you have any questions, please contact Kerry-Anne Henry at:

KerryAnne.Henry@dcf.nj.gov
609-888-7204

Thank you for taking the time to complete this survey.

KFT Quarterly Report – Paper Version of Services Survey

CASE INFORMATION

DCP&P Case ID #:		Reporting Date (MM/DD/YYYY):			
Parent 1. First Name:		Parent 1. Last Name:		Person 1. DCP&P Person ID #:	
Parent 2. First Name:		Parent 2. Last Name:		Person 2. DCP&P Person ID #:	

SERVICES

Housing Case Management (with Housing Specialist):

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in individual face-to-face case management sessions? ☐ Yes ☐ No	Did this person participate in individual face-to-face case management sessions? ☐ Yes ☐ No
If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter
If yes, how long on average did the face-to-face meetings last (choose one)? If no, skip this question. ☐ 30 minutes ☐ 1 hour ☐ 1.5 hours ☐ 2 hours ☐ More than 2 hours	If yes, how long on average did the face-to-face meetings last (choose one)? If no, skip this question. ☐ 30 minutes ☐ 1 hour ☐ 1.5 hours ☐ 2 hours ☐ More than 2 hours

Did this person participate in individual phone case management sessions? ☐ Yes ☐ No	Did this person participate in individual phone case management sessions? ☐ Yes ☐ No

Housing Case Management (continued):

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

Clinical Case Management (with Clinician):

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Has a treatment plan been completed? ☐ Yes ☐ No	Has a treatment plan been completed? ☐ Yes ☐ No
If yes, has the treatment plan been reviewed this quarter? If no, skip this question. ☐ Yes ☐ No	If yes, has the treatment plan been reviewed this quarter? If no, skip this question. ☐ Yes ☐ No
Did this person participate in individual face-to-face clinical/therapy sessions? ☐ Yes ☐ No	Did this person participate in individual face-to-face clinical/therapy sessions? ☐ Yes ☐ No

If yes, how often on average did they participate? If no, skip this question.	If yes, how often on average did they participate? If no, skip this question.
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

Clinical Case Management (continued):

Child(ren):
Did any child(ren) participate in individual face-to-face clinical/therapy sessions? ☐ Yes ☐ No
If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter
Family:
Did this family participate in face-to-face clinical/therapy sessions? ☐ Yes ☐ No
If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

Groups:

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**

Did this person participate in any program groups (Family Fun, Recovery, Self-Care/Wellness, Healthy Interactions/Parenting Groups)? ☐ Yes ☐ No	Did this person participate in any program groups (Family Fun, Recovery, Self-Care/Wellness, Healthy Interactions/Parenting Groups)? ☐ Yes ☐ No

Groups (continued):

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
If yes, which groups did this person participate in (choose all that apply)? ☐ Family Fun ☐ Recovery ☐ Self-Care/Wellness ☐ Healthy Interactions/Parenting	If yes, which groups did this person participate in (choose all that apply)? ☐ Family Fun ☐ Recovery ☐ Self-Care/Wellness ☐ Healthy Interactions/Parenting
If yes, how many group sessions did this person attend during the quarter (write in)? If no, skip this question. _____	If yes, how many group sessions did this person attend during the quarter (write in)? If no, skip this question. _____

Professional Development Services:

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in an initial assessment session with the employment specialist? ☐ Yes ☐ No	Did this person participate in an initial assessment session with the employment specialist? ☐ Yes ☐ No
Did this person participate in ongoing sessions with the employment specialist? ☐ Yes ☐ No	Did this person participate in ongoing sessions with the employment specialist? ☐ Yes ☐ No

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in any employment and professional development workshops led by the employment specialist? ☐ Yes ☐ No	Did this person participate in any employment and professional development workshops led by the employment specialist? ☐ Yes ☐ No

Substance Abuse Services:

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in services with the substance use counselor? ☐ Yes ☐ No	Did this person participate in services with the substance use counselor? ☐ Yes ☐ No
If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

Agreement to Take Part in the Keeping Families Together Program Evaluation

Purpose

The New Jersey Department of Children and Families is collecting information to understand the impact and effects of the Keeping Families Together program. The study will provide information to help improve supportive housing services for parents and their children and may also help to determine whether this program should be expanded statewide.

The purpose of the study is to learn more about whether the Keeping Families Together program is doing a good job of helping families to remain together in safe, stable housing and improve their overall well-being.

What does it mean to be in the study?

Families enrolled in the Keeping Families Together program will be asked to participate in this study.

If you agree to participate, we will ask you to do the following:

- **Agree to be contacted by telephone or mail in the future about participation in an interview or focus group.**

  We will ask your Keeping Families Together program staff to provide us with your current contact information such as a telephone number or address, so a member of the study team may contact you in the future. By signing this agreement, you are not agreeing to participate in an interview or focus group. You are only agreeing to be contacted in the future with additional information and a request to participate.

- **Allow us to obtain information from your Keeping Families Together program after your Child Protection and Permanency case closes.**

  While you are participating in a Keeping Families Together program, we will ask the program to provide information on you and your family. This may include your family demographics, any service needs that have been identified, and the services you are receiving through the program. We may also collect information from any assessment tools that your Keeping Families Together program has administered.

Being part of the study is your choice

Taking part in the study is your choice. If you decide not to be in the study, there is no penalty. Your decision will not affect your enrollment or participation in your Keeping Families Together program. You may opt out of the study at any time.

Risks & Benefits

There are no risks to participating in this study. There are also no direct benefits to your families for participating. However, taking part in the study might help improve supportive housing services in the future.

Information will be private

Any information provided about you and/or your family will be confidential. The study team follows strict rules to keep your information private. Information provided by your Keeping Families Together program will be entered into a secure data system, and only authorized staff will be able to view identifying information. No reports will include your name or identifying information or will describe you in a way that would allow you to be identified.

We will keep your information private unless there is concern that you or someone else may be harmed or put in serious danger. For example, we would tell someone if we see evidence of child abuse or neglect.

If you have questions, please connect with DCF's Office of Housing at DCF.OfficeofHousing@dcf.nj.gov.

Participant's Statement

"The research procedures, risks, and benefits have been explained to me. I recognize that I am free to ask any questions. I understand that taking part in this study is my choice. I understand that I am free to stop taking part in the study at any time. I understand that any information that can be used to identify me will be kept private, unless there is concern that I or someone else may be harmed.

I agree to allow my Keeping Families Program to provide my contact information to the study team, so that I can be contacted in the future. I agree that the New Jersey Department of Children and Families and any additional members of the study team may obtain information from my Keeping Families Together program about me and my family."

Agreement to participate in the study:

_____

Print Name

_____ _____

Signature Date

ADDITIONAL RESROURCES

POEM BY NJ KFT PARENT

I walk down the street.

There is a deep hole in the sidewalk.

I fall in.

I am lost…I am helpless.

It isn't my fault.

It takes forever to find a way out.

I walk down the same street.

There is a deep hole in the sidewalk.

I pretend I don't see it.

I fall in again.

I can't believe I am in the same place.

But, it isn't my fault.

It still takes me a long time to get out.

I walk down the same street.

There is a deep hole in the sidewalk.

I see it is there.

I still fall in. It's a habit.

My eyes are open.

I know where I am.

It is my fault. I get out immediately.

I walk down the same street.

There is a deep hole in the sidewalk.

I walk around it.

I walk down another street.

-NJ KFT Parent

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ADDITIONAL READING AND RESOURCES

This section is intended to highlight additional resources and reading materials that may be useful for practitioners and Provider Partners seeking more context about housing, supportive housing and related areas. Note, these resources and suggested reading materials are not essential to understanding the NJ KFT intervention. Finally, the materials included below are not intended to be an exhaustive list, but instead may serve as a springboard to broaden an understanding of the societal context within which NJ KFT exists and how these elements influence the intervention.

Housing and Race Equity

Book Recommendation: The Color of Law
Book Recommendation: Evicted
Race Equity and Fair Housing
Equity at the Center of Implementation

Housing and Health

Million-Dollar Murray
Housing and Social Determinants of Health
Housing is the Best Medicine

Housing as an Intervention

KFT Matters: An Introduction to Creating Supportive Housing for Child Welfare-Involved Families
A Practice Framework for Delivering Services to Families in Supportive Housing
Past, Present, and Future of Supportive Housing in Connecticut
Welcome Home: Design and Practice Guidance for Supportive Housing for Families with Children
Permanent Supportive Housing: Building Your Program
Permanent Supportive Housing: Getting Started with Evidence-Based Practices (samhsa.gov)
Permanent Supportive Housing: How to Use the Evidence-Based Practices KITs (samhsa.gov)
Permanent Supportive Housing: Tools for Tenants (samhsa.gov)
Permanent Supportive Housing: Training Frontline Staff

Ending Homeslessness

National Alliance to End Homelessness
United States Interagency Council on Homelessness
U.S Department of Housing and Urban Development
NJ Department of Human Services

"This program has given me the opportunity to think about hopes and dreams. Not having to think about where my children will sleep or whether we can get into the house when we get home, is freeing."

APPENDICES

APPENDIX A
DCF ACTIVE IMPLEMENTATION

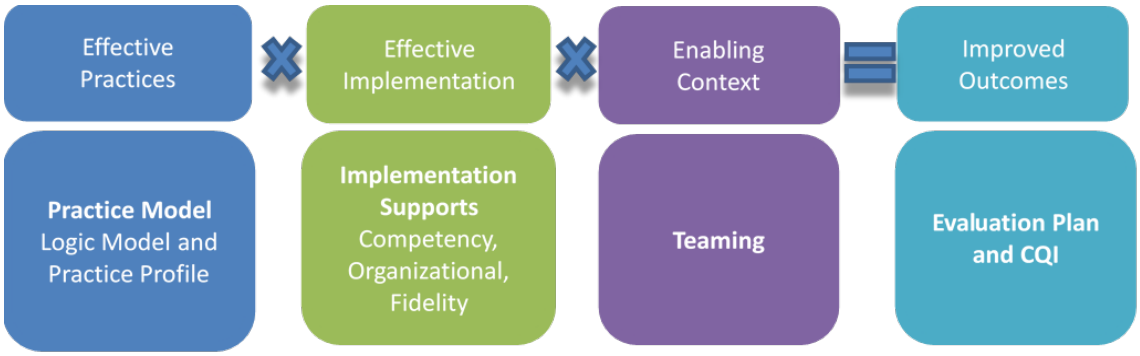
NJ DCF Approach:

The field of implementation science provides frameworks to help assess and support the design and implementation of interventions so that outcomes can be achieved[1] [2]. For innovative programs that are informed by literature, but have yet to be evaluated, the practice must be defined, implementation supports (training, coaching, fidelity tool, etc.) must be developed to support the practice, and data collection and evaluation must be established for ongoing practice improvements so that targeted outcomes can be achieved.

The National Implementation Research Network (NIRN)[3]has summarized implementation science through the following formula, which the Department has adopted as its organizing framework to manage the complexities of this work:

The formula demonstrates that improved outcomes for children and families can be achieved when there is an effective practice, effective implementation supports, and an enabling context. These elements have a synergistic effect with desired outcomes only achieved through the interaction of all three factors.

DCF systematically utilizes the Active Implementation Framework and accompanying tools to help the Department organize and strengthen existing innovative practices. Below is a visual of NIRN's Active Implementation Formula[4] with the specific components that are needed to factor into the equation. Programming, whether new or existing, is assessed for the presence or absence of each factor component. When a component is absent, it is co-created through a teaming structure that includes stakeholders with the necessary expertise.



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[4] Metz, A., Bartley, L., Maltry, M. (2017). *Supporting the Sustainable Use of Research Evidence in Child Welfare Services, An Implementation Science and Service Provider Informed Blueprint for the Integration of Evidence Based/Evidence Informed Practices into NJ Child Welfare System.* The National Implementation Research Network.

Below is a description of each of the components of the Active Implementation formula:

Teaming	Multi-level teaming structures move programs, practices, and strategies from an idea to full implementation and ensure consistent internal and external communication within and between teams. Teams meet regularly, have dedicated appointments, and work in a structured way with agendas, meeting notes, action items, timelines, workplans and project management.[5]
Practice Model Logic Model and Practice Profile	For an intervention or practice to be effective, it must be well-defined by a logic model and practice profile. A logic model is a roadmap that describes what results one hopes to achieve by doing specified activities. A practice profile is a tool for operationalizing an intervention so that staff, supervisors, and directors in implementing agencies have a clear understanding of what they are expected to do when implementing the practice. A practice profile includes guiding principles and essential functions. Guiding principles are the philosophies, values and beliefs that inform specific interventions. Essential functions describe the practice elements and promote consistency across staff and providers.[6]
Implementation Supports Competency, Organizational, Fidelity	To ensure that staff are prepared to implement the practice well, staff selection criteria (job descriptions and interview protocol), skill-based training, and follow up coaching to reinforce the training must be in place. In addition, organizational supports such as clear administrative processes, data collection/data systems to support decision-making, and processes for systems coordination are needed so that the context in which the program is being implemented can be established, and to ensure that the factors connected to the implementation are hospitable for the intervention to succeed.[7] [8]
Evaluation Plan and CQI	Data is used to support program implementation, ensure intervention fidelity, and assess child & family outcomes. Continuous Quality Improvement (CQI) involves developing a process for identifying, collecting, and analyzing data that are useful to make decisions on improvement. This process should be ongoing.[9]

[5] Metz, A., Bartley, L., Ball, H., Wilson, D., Naoom, S., & Redmond, P. (2015). Active implementation frameworks for successful service delivery: Catawba County Child Wellbeing Project. *Research on Social Work Practice*, 25, 415-422.

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APPENDIX B
NJ DCF KEEPING FAMILIES TOGETHER LOGIC MODEL

NJ Keeping Families Together Logic Model

Vision: To keep families together by providing safe, permanent housing and evidence-based, trauma-informed support services to CP&P-involved families using a Housing First approach.

Name of Initiative: NJ Keeping Families Together (KFT)

Target Population: DCP&P involved families with high needs whose challenges with homelessness or housing instability place their children at risk of out-of-home placement or have delayed reunification with children currently in out-of-home placement.
*Specific requirements may vary across sites, "high needs" is generally defined as having multiple risk factors which may include substance use disorders, medical/mental health disorders, domestic violence, developmental disability (child), trauma history etc.

RESOURCES	ACTIVITIES	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Overarching Philosophy of "Whatever It Takes" **Staffing:** Program Manager/Supervisor KFT Practitioner KFT Champion Clinician **Collaborations:** Families DCP&P State Partners (DCA, DHS etc.) Housing Providers (Landlords, Developers etc.) Community Stakeholders **Data Collection Systems and Tools:** Agency data systems NJ DCF data portal *Tools Include:* Baseline Family Survey Services Survey Caregiver Satisfaction Survey **Assessment and Evaluation:** Collection of Assessment and Evaluation Tools that support Continuous Quality Improvement Practices **Training, Supervision and Coaching:** NJ KFT Training and Coaching Curriculum	**Intake and Enrollment** Includes assessing initial eligibility, facilitating the enrollment, and providing pre-tenancy services (i.e., initial voucher application and housing search/navigation). **Stabilization and Maintenance** Includes initial needs assessment and case planning to support the provision of the following, NJ KFT Services: – Case management* (Housing and Support Services) – Clinical Services (Individual and Group Sessions) – Concrete support ▪ One-time financial support (i.e., security deposits and other move-in costs) ▪ Transportation (limited availability) – Linkage to community-based resources **Moving On and Aftercare** **This may include the provision of employment, education support or other professional development services, as needed throughout the intervention.* ********** **Systems Collaboration with Key Partners** DCP&P – NJ KFT Provider partners engage in regular phone and in-person contact, participate in FTMs and case conferences, provide written collaterals (which includes progress notes and/or court reports), and other documentation, *as needed while the case remains open.* Housing Partners – NJ KFT Provider partners consistently engage with State agencies (i.e., NJ Department of Consumer Affairs), local Public Housing Authorities (PHAs), Landlords and Housing Developers, Continuums of Care (CoC) and a host of community partners to successfully support families in housing.	Improve housing stability for child welfare involvement families Improve caregiver reported well-being (parenting) Improve child reported well-being Improve family stability (i.e., income, employment)	Reduce recidivism within the child welfare system Integrate housing services within the child welfare services landscape

Assumptions:

- Per the Housing First approach, individuals and/or families are more likely to consistently meet their other needs when they are first provided with stable housing.
- Reducing fragmentation of services, including CPS, increases the likelihood that families will participate consistently in support services.
- NJ KFT staff will consistently implement the model as intended using a "whatever-it-takes" approach to support families.

APPENDIX C
NJ KFT PRACTICE PROFILE

Keeping Families Together (KFT) Practice Profile

Guiding Principles: *Philosophies, values, or beliefs that programs have when working with families.*
➢ **Trusting Relationships:** Trusting relationships promote positive change and growth in families. Building and maintaining a trust-based relationships with family members is essential when working toward long-lasting change and positive outcomes. KFT programs encourage open communication and cultivate trust with family members. Families should view KFT programs as a source of support and assistance, both for routine services as well as in times of crisis. Every interaction with family members is an opportunity for further engagement and alliance-building.
➢ **Housing Stability:** Housing stability is a platform for the teamwork that supports the well-being of families. Safe, stable and affordable housing provides a foundation for ongoing work with family members to set and work towards goals, including the sequencing of any services. KFT programs work with families toward the overall goal of well-being and enhancing the family's ability to stay safely housed together, including helping family members heal from past traumas, build resilience, maintain the household, build finances and be positively involved in their community. Practices, such as case conferencing and team clinical supervision, allow staff, supervisors and others who support family members and/or supportive housing staff to share information, troubleshoot difficult situations and reinforce a non-judgmental, supportive and collaborative culture for the work. Family members themselves are an integral part of the work to set and meet goals. Team meetings and other consistent modes of communication that meaningfully involve family members, should be used to further engage families in the ongoing assessment of progress, formulating goals and identifying when the team should expand or contract based on family functioning. The team can be composed of professionals, representing formal supports, and non-professionals or informal supporters (relatives, friends, mentors) who are part of the family's circle. KFT programs help family members build their circle of support by recognizing when relationships may not serve the family's goals and repairing others, as needed.
➢ **Flexible:** There is flexibility in time and place for responding to the needs of families. The strength of the supportive housing model is that it provides unique opportunities to witness and respond to family circumstances in real time, sometimes on a daily basis, depending on the setting. The work of KFT program staff goes beyond their desks. Meetings and collaborations with family members and others take place in the family's home, in schools, at local restaurants, or a parent or youth's work places. Often contact does not take place within the hours of 9-5.
➢ **Voluntary Participation:** Services may not have time limits and are voluntary. The intensity of case management services is responsive to individual family need and circumstances. Families with complex and persistent service needs such as psychiatric or specialized medical care may need ongoing interventions. At times, KFT programs will have to "dial up" or increase the frequency and depth of family contact. At other times, KFT programs will "dial down" or decrease the frequency of contact, recognizing that family members are making strides on their own. After achieving stability and improved outcomes, some families may no longer need or want as many formal supports or as much contact with KFT programs. Such decisions should be made based upon mutual agreement between KFT programs and family members; acknowledging and being responsive to a family's wishes, needs and progress. A family's trusting relationship with KFT programs should reinforce a culture of open communication where a family's changing needs can be discussed and addressed; leaving the option open to request more help in the future if needed.

Guiding Principles: *Philosophies, values, or beliefs that programs have when working with families.*
➢ **Community Connections:** Community support is essential to helping families strengthen their own networks. Stress and isolation undermine physical and emotional health and positive parenting. KFT programs actively work to build community and a culture of support and interaction among families involved with supportive housing, as well as with their neighbors who are not involved with the supportive housing program and the community at large. There will be families who have learned not to trust their neighbors and would rather engage in activities outside the immediate community, or not engage at all. Opportunities to connect to other families both in the supportive housing program and in the larger community should be offered on an-ongoing basis. When considering community connections and support services, it is crucial for KFT programs to understand that although support services have no established time limit it is the expectation that many families will move on from supportive housing to less intensive services environments within the community. Valuing a moving on perspective is also crucial to ensuring scarce resources are applied most efficiently and facilitate KFT families in moving on from supportive housing to affordable housing in the community, that is independent of services.
➢ **Trauma and Evidence-Informed:** Strategies are trauma-informed. KFT programs should be aware of the stressors with which many families live and the fact that many family members have been and continue to be exposed to a range of traumatic experiences, for example: community violence, domestic violence, physical abuse, and complex grief. Exposure to multiple or prolonged traumatic events, typically beginning in early childhood and occurring within the primary caregiving system, produces complex trauma. KFT programs should have the skills to identify and appropriately respond to trauma symptoms. Organizations, including supportive housing settings, have become much more aware of how the physical environment of office spaces and even administrative procedures may illicit negative responses related to a person's experiences with stress and trauma. Evidence-based or informed strategies, such as Motivational Interviewing, have a high probability of producing desired outcomes. Such strategies should be used by KFT programs when providing services to family members. There are several directories of evidence-based therapeutic interventions and programs that can be consulted. But any intervention selected, whether it be from one of these directories or from other reliable sources and valid research, needs to be well matched to family strengths and needs in order to ensure its effectiveness. Interventions should make sense in the family's context and be complementary. Strategies are to be evaluated continuously to ensure their efficacy, or lack thereof, in order to make adaptations promptly and to put in place alternative strategies that may be more likely to succeed.

Essential Functions - *Activities that allow the program to be teachable, learnable and doable*	
Engaging	*A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.*
Assessing	*The ongoing process of acquiring the knowledge to understand strengths and needs of family members for effective decision making with family members and linkage to the most appropriate interventions. Identifying where family members are in the change process. Facilitating critical thinking and discussions with family members and their formal and informal team/supporters about the family's underlying needs, how they define problems and what success looks like. Assessments and service plans are focused on factors such as promoting child development, responsiveness to trauma, building protective and promotive factors for families.*
Family Involved Teaming	*A deliberate and structured approach to involving youth and families in decision-making through facilitated meetings of family members, their identified supports and professionals working with the family. Building a network of support with and for family members that consists of both non-professional and professionals, as needed, who work together to help family members meet their goals. Identifying and defining the roles of all teams within the larger support network.Collaborating and coordinating across systems with and for families. Recognizing and appreciating the strength and support that a family's community, cultural and other natural relationships can provide. Establishing shared commitment and accountability with family members and others taking on their roles and responsibilities, holding themselves and others accountable for meeting goals. Creating an environment for psychologically safe, open and honest communication with the family and their formal and informal supports, facilitating continuous dialogue about the quality of services and adjustments needed. Identifying and defining the roles of all teams within the larger support network. Collaborating within individual and between all the various teams, involving all components of the family's support system at all levels. Respectful and meaningful collaboration with families (and community partners) to achieve shared goals.*
Tracking and Adjusting	*Following up on the intervention delivery processes through regular communication with family members and service providers to understand progress being made, barriers encountered and changing family circumstances. Regularly updating service needs assessments and individualized service plans to reflect the changing service needs and goals of family members.*
Advocating and Educating	*Speaking up for families and serving as a role model in order to support them in strengthening their family, meeting their needs, finding their voice and developing their ability to advocate for themselves. Coordinating with the family's formal and informal advocates to assist the family to find their own solutions. Encouraging, supporting and providing opportunities for family members to actively share their voice, offer solutions, act as leaders and be central in assessment, planning and decisions about their lives. Helping families advocate for themselves and others for system and policy improvements. Supporting the development of increased knowledge and skills needed to follow through with the identified goals. These goals could include parenting, home management, mental health, nutrition, self-care, etc.*
Planning and Linking to Services	*Collaborate with the family to develop appropriate family-centered/-driven goals that are attainable within identified realistic timeframes. Without agreed upon goals and plans, families may only reach out when in crisis. Some common areas for goal setting in supportive housing include: Maintaining Housing (budgeting, physical maintenance, being a good neighbor etc.), Substance Use, Daily*

Essential Functions - *Activities that allow the program to be teachable, learnable and doable*	
	Living Skills, Legal Concerns, Vocation/employment, Education, Family/Parenting, Childcare/school, Leisure/socialization, Medical/health, Spirituality.
Clinical Intervening	*Purposeful use of evidence based/informed approaches intended to help families identify and process emotions and practice positive coping skills.*

Essential Function		
<u>Engaging</u> *A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
• **Initiates and maintains ongoing phone and in-person contact with family.** • Introduces self and program to CP&P staff and stakeholders including resource parents, service providers, court/legal personnel and any additional family members, etc. and answers any emergent questions, preferably in a phone call. ○ Schedules appointments at time and place that is convenient for the family and confirms visits, *as needed*. ○ Directly accessible to families 24 hours per day, 7 days per week (including holidays), 365 days per year through the distribution of their cell phone number. ○ Discusses program participants roles and responsibilities which may include: ▪ Clearly explaining expectations, policies and procedures of the program; ▪ Clarifying time frames for working with the family; and/or ▪ Informing the family of their rights and responsibilities. ○ Always engages in a transition process when staff changes. Process should include internal case conferencing and discussion of transfer details with family, CP&P and relevant stakeholders. • **Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.** ○ Actively seeks opportunities to engage in regular communication with CP&P and other stakeholders by phone, in person and/or written collateral contacts.	• **Typically initiates and maintains ongoing phone and in-person contact with family.** ○ Introduces self and program to CP&P staff and stakeholders including resource parents, service providers, court/legal personnel and any additional family members, etc. but may not always answer emergent questions. ○ Usually schedules home visit(s) at a time that is convenient for the family. ○ At times is inaccessible to families during non-traditional hours (i.e., after 5pm, weekends, holidays etc.). ○ Facilitates discussion of program participants roles and responsibilities, but key points may be missed. ○ Always engages in a transition process when staff changes. Sometimes include internal case conferencing and discussion of transfer details with family, CP&P and relevant stakeholders. • **Usually initiates and maintains ongoing contact with CP&P and other stakeholders.** ○ Misses opportunities to initiate communication with CP&P and other stakeholders. ○ Inconsistently invites CP&P staff and stakeholders to participate in FTMs. ○ Provides some education to stakeholders about the KFT model and working with the family.	• **Contacts families on a limited or sporadic basis.** ○ Home visit(s) are often scheduled without input from the family and staff is often unavailable to families. ○ Rarely clarifies roles and responsibilities. ○ Transition processes are unorganized and frequently doesn't include the family's input. • **Contacts with CP&P and other stakeholders is limited, if they occur at all.** ○ Regular communication with stakeholders is rare and there are many opportunities to teach stakeholders about the program model. • **Communication with families and stakeholders is often judgmental and culturally insensitive.** • **Struggles to consistently employ MI techniques.** ○ Seldom employs active listening skills and frequently asks closed-ended questions. ○ Sometimes makes reflective statements. ○ There are missed opportunities to encourage the parent to explore or elaborate on a topic. ○ Rarely or never makes affirmations to the parent and inconsistently utilizes reframing.

Essential Function		
<u>Engaging</u> *A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.*		
Expected *includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts*	**Developmental**	**Unsatisfactory**
○ Invites CP&P staff and stakeholders, with family's consent, to participate in Family Team Meetings and discusses their role and input in supporting the family. ○ Educates stakeholders about the program model and approach to working with the family. • **Communicates in an open, honest, respectful and culturally sensitive manner.** ○ Approaches all interactions with families with openness and a nonjudgmental attitude by: ▪ Listening without making assumptions; ▪ Using language that everyone can understand; ▪ Checking in frequently on communication styles and terms to ensure understanding; ▪ Using empathy particularly when discussing sensitive topics through reflection, body language, and sensitive responses; and/or ▪ Respecting the family's faith, culture and existing family rituals. ○ Consistently models honest and respectful communication by: ▪ Communicating a sincere desire to be respectful ("I would like to be respectful, how should I address you?"); ▪ Addressing individuals by the name or title they request; ▪ Responding to questions and describing situations honestly; ▪ Providing relevant facts and information; ▪ Making clear statements about what information or action is being requested of the family; and/or	• **Generally communicates in an open, honest, respectful and culturally sensitive manner.** ○ Frequently approaches interactions with families with openness and a nonjudgmental attitude. ○ Usually models honest and respectful communication. • **Inconsistently employs MI techniques.** ○ Often employs active listening skills and open-ended questions to engage the parent. ○ Demonstrates some ability to respond with unconditional, positive regard to arguing, interrupting, negating (denial), ignoring or other parental behaviors. ○ Always makes reflective statements and usually conveys to the parent an effort to understand their point of view. ○ Generally, encourages the parent to explore or elaborate on a topic and uses affirmations to support parent. ○ Inconsistently reframes by acknowledging what the parent said. ○ Infrequently comes alongside the parent. • **Inconsistently uses a family-centered approach.** ○ Recognizes the parent as a partner in the process but at times struggles to use a parent-centered approach. ○ Generally, creates an environment that allows people to discuss family history and needs. ○ Usually uses strengths-based, solutions-focused, family centered and trauma informed strategies to elicit family input.	○ If often at odds with the parent's perspective. • **Seldomly uses a family-centered approach.** ○ Often recognizes formal partners and ignores the parent as a partner in the process. ○ Often creates an environment where families are hesitant to discuss their history, needs and progress on goals. ○ Strengths-based, solutions-focused, family centered, trauma informed strategies are often not observed during interactions. ○ Demonstrates little to no understanding of the impact of family dynamics, intergenerational struggles, ethnicity and culture on family functioning. ○ Rarely incorporates family's ideas into planning service and doesn't acknowledge family strengths. ○ Often misses, or doesn't acknowledge, non-verbal communication cues. • **Creative outreach and family engagement strategies are rarely utilized, if at all.** ○ Occasionally facilitates social events/activities that are often not aligned with family needs (i.e., scheduling a parent group session after school hours without planning for childcare).

Essential Function		
<u>Engaging</u> *A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.*		
Expected *includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts*	**Developmental**	**Unsatisfactory**
▪ Facilitating dialogue regarding how the requested information and actions will affect the situation and support the family. *[3, 5, 7, 11, 17,18,19]* • **Consistently employs Motivational Interviewing techniques.** *[10,17, 20]* o Employs active listening skills and focuses on showing both verbal and non-verbal signs of listening, to understand the parent. o Demonstrates a clear ability to respond with unconditional, positive regard to arguing, interrupting, negating (denial), ignoring or other parental behaviors. o Asks various open-ended questions that invite parent conversation as opposed to asking only yes/no response questions. For example, asks: ▪ So, what brings you here today? ▪ What are some of the ways that substance use affects your life? ▪ What kinds of differences have you noticed in? o Makes reflective statements that restate the parent's comments using language that accurately clarifies and captures the meaning of the parent's communications and conveys to the parent an effort to understand the parent's point of view. Encourages the parent to explore or elaborate on a topic by: ▪ Repeating exactly what the parent just stated ▪ Rephrasing by slightly rewording ▪ Paraphrasing by amplifying thoughts or feelings, using analogies, or making inferences	o Demonstrates a general understanding of the impact of family dynamics, intergenerational struggles, ethnicity and culture on family functioning. o Typically incorporates family's ideas into planning processes and services. o Frequently acknowledges existing family strengths but inconsistently uses them as the basis of growth and change. o Often validates family's thoughts and feelings and may not always recognize non-verbal communication. • **Generally, uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.** o Sometimes facilitates social events/activities (e.g., holiday parties, support groups, games).	

Essential Function		
<u>Engaging</u> *A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
▪ Reflecting the parent's statements in an exaggerated manner ▪ Restating what the parent has said, but reminding them of the contrary things they have said previously ▪ Using reflective summary statements by selecting several pieces of parent information and combining them in a summary with the goal of inviting more exploration of material, to highlight ambivalence, or to shift focus by making a transition to another topic the parent is less ambivalent to exploring and changing. o Makes affirmations such as; ▪ Using compliments or praise; ▪ Acknowledging the parent's personal qualities, competencies or abilities that might promote change; ▪ Recognizing effort or small steps taken by the parent to change; and/or ▪ Using a positive reframe to affirm the parent (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the parent's persistence in trying to deal with his or her drug use problems and not giving up). o Reframes by acknowledging what the parent has said, but offers a different perspective o Comes along side the parent to take the side of no change as a way to foster the parent's ambivalence and elicit change talk. • **Consistently uses a family-centered approach.** o Recognizes the parent as a partner in the process and consistently uses a parent-centered approach.		

Essential Function		
<u>Engaging</u> *A continuous process of staying delicately in step with family members in order to continue to build working relationships to support ongoing assessments, understanding and service decisions. Focus is on the person's immediate, practical concern (starting where they are) in each encounter. Always seeking out family members, building rapport, inviting into a change process, valuing and making central the power, perspectives, abilities and solutions they and their supportive communities offer.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
○ Creates an environment that allows people to discuss family history and needs and communicates that family members are full partners in defining their needs, designing a plan of action to meet their needs, and reviewing their progress. ○ Uses strengths-based, solutions-focused, family centered and trauma informed strategies to elicit family input. ○ Demonstrates an understanding of the impact of family dynamics, intergenerational struggles, ethnicity and culture on family functioning. ○ Incorporates family's ideas into planning processes and services. ○ Acknowledges existing family strengths and used as the basis of growth and change. ○ Creates opportunities for families to discuss feelings and reactions about changes family dynamics (i.e CP&P case goal, etc.). ○ Validates family's thoughts and feelings. ○ Recognizes non-verbal communication. • **Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.** ○ Facilitates regular social events/activities (e.g., holiday parties, support groups, games) to promote social networking, interaction, and community-building among families. *[1,5,14]*		

Essential Function		
Assessing *The ongoing process of acquiring the knowledge to understand strengths and needs of family members for effective decision making with family members and linkage to the most appropriate interventions. Identifying where family members are in the change process. Facilitating critical thinking and discussions with family members and their formal and informal team/supporters about the family's underlying needs, how they define problems and what success looks like. Assessments and service plans are focused on factors such as promoting child development, responsiveness to trauma, building protective and promotive factors for families.*		
Expected *includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts*	**Developmental**	**Unsatisfactory**
• **Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.** *[13,15]* • **Uses a process to gather information.** ○ Communicates with the family and all providers involved (e.g., CP&P, teachers, pediatricians, psychiatrists) to gather and document biopsychosocial information to guide the intervention by: ▪ Asking questions by phone and/or during in person meetings with family, CP&P workers and other collateral providers. ▪ Reviewing CP&P referral form and contacts CP&P worker for family and case specific information. ▪ Gathering information from relevant sources. This may include information from: case records, the child's school reports, substance use evaluations, medical reports, mental health assessments, and any other relevant information to inform the assessment of the family. ▪ Observing family's interaction during contacts. ▪ Conducting discussions appropriate to the developmental age, stage and capacity of the family member (such as those of a child or youth or cognitive delay for an adult) ▪ Checking assumptions, listening and communicating understanding during conversations ○ Inquires or guides a discussion about the risk factors driving the need for KFT intervention (treatment), to develop a full understanding of the nature of the parent's difficulties and provide feedback using a non-judgmental, curious, collaborative parent-centered style.	• **Typically conducts the initial meeting with family in a private setting.** • **Usually uses a process to gather information.** ○ Typically communicates with the family and support network to gather and documents information to guide the intervention. ○ Inquires or guides a discussion about the risk factors driving the need for KFT but does not always provide non-judgmental feedback. ○ Inquiries about family history and goals but misses opportunities to collect ongoing and evolving needs of family members. • **Typically completes required assessment tools.** ○ Accurately administers standardized assessment tools but sometimes misses designated timeframes. Sometimes provides limited explanation to the family about the tools. ○ Records the results of assessments but not always using nonjudgmental language. • **Usually synthesizes information and completes service plan.** ○ Sometimes misses opportunities to discuss observations and assessments with parents and elicit feedback regarding goal setting. ○ Uses the family's perspective and input, inconsistently including collateral information from CP&P and other providers, to support planning and decision making. ○ Usually uses language and concepts the family uses and incorporates the family's strengths, resources, cultural perspective and solutions in all actions. ○ Frequently assists with prioritizing family members' goals by initiating a discussion of the stages of change or level of	• **Family meetings are often facilitated in a setting where other people can hear the discussion.** • **The process for gathering information is inconsistent and unorganized.** ○ Communication with the family and support network is sparse; there are many missed opportunities to gather and document relevant information. ○ The discussion about family risk factors is limited and often leaves many unanswered questions about the family's needs. ○ The parent's request for formal feedback often goes unanswered. ○ When provided, feedback is at times judgmental. • **Does not demonstrate understanding of required assessment tools.** ○ Inaccurately administers assessment tools, if at all. ○ Often does not explain to the family the intention of the tools being administered. • **Rarely synthesizes information and completes service plan.** ○ Struggles to use formal and informal techniques to better understand the family. ○ The family's voice is absent in the information gathering process.

○ Provides formal feedback if solicited by the parent or when seeking the parent's permission first. ○ Inquires about family history, goals, and ongoing and evolving needs to collect and confirm information by exploring with family members: ▪ Strengths, hopes, dreams, needs, goals, opportunities, solutions; ▫ What is important in their present? ▫ Where would they like to be "down the road?" ▪ How, and to what extent, they identify with traditions of their cultures, communities, Tribes?; ▪ Past encounters and experiences with service systems – services received, diagnoses given; [4,11] ▪ Who are the family's natural supports? (Examples include maternal and paternal relatives, close friends, and community resources and supports); and/or ▪ Where they are in the change process at any given time? As a reminder, the stages include: ▫ STAGE 1: Not Ready (Pre-contemplation) ▫ STAGE 2: Getting Ready (Contemplation) ▫ STAGE 3: Ready to Take Action (Preparation) ▫ STAGE 4: Taking Action (Action) ▫ STAGE 5: Ready to Maintain Gains (Maintenance) *[4,9,12,19]* • **Completes required assessment tools.** ○ Administers and accurately completes standardized assessment tools within designated timeframes, explaining to the family what is hoped to learn from them. Tools may include: ▪ Bio-psychosocial assessment with parent and child; ▪ Modified Arizona Self-Sufficiency Matrix; and/or ▪ KFT Baseline Survey and follow-up Services Survey at identified intervals ○ Records the results of assessments in nonjudgmental language. • **Synthesizes information and completes service plan.**	motivation by helping the family members develop a rating of importance, confidence, and readiness or commitment. • **Inconsistently assesses and updates the Service Plan at regular intervals.** ○ Sometimes assesses whether adjustments are needed during the intervention. ○ Review the Service Plan at least every 3 months, or as necessary, but may inconsistently include the larger team.	○ Often disregards collateral information from formal supports (i.e., CP&P). ○ Typically, there are many missed opportunities to guide the family regarding goals and behaviorally specific action items to achieve the identified goals. ○ Frequently uses jargon that the family doesn't understand. ○ Rarely, if at all, discusses the stages of change or level of motivation with the family. • **Seldom updates the Service Plan.** ○ Typically reviews the service plan only when prompted, by supervisor, instead of indicated intervals or as needed.

○ Uses formal and informal techniques to understand the strengths, interests, goals, needs, risks, stressors, and underlying issues of family members within the culture and context of the child and family. ○ Discusses observations and assessments with parents and elicits feedback regarding goal setting. ○ Uses the family's perspective and input, including collateral information from CP&P and other providers, to develop an accurate picture of the family for planning and decision making. ○ Incorporates gathered information from reviews, inquiry, observations, parent feedback and assessments in a Service Plan which includes recommendation of the family's goals and behaviorally specific action items to achieve the identified goals. ○ Uses language and concepts the family uses and incorporates the family's strengths, resources, cultural perspective and solutions in all actions ○ Assists with prioritizing family members' goals by initiating a discussion of the stages of change or level of motivation by helping the family members develop a rating of: ▪ Importance: How important is the goal? Make it meaningful. ▪ Confidence: How confident is the person that they will achieve the goal? Focus on the one the individual believes they could achieve first. (As one achieves simpler goals, it builds confidence and empowers to tackle more difficult ones.) ▪ Readiness or commitment: Discusses ambivalence in detail or explicitly facilitates a costs/benefits analysis with parent input concerning change versus remaining the same. Specific techniques used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons. • **Continually assesses and updates the Service Plan at regular intervals.**		

○ Continues to assess throughout the intervention to determine if adjustments are needed during the intervention (e.g., review family's continued safety, growth and development). ○ Reviews the Service Plan at least every 3 months or as necessary to determine progress, update goals, and in consultation with the larger team determine whether it is appropriate to change the intensity of services. *[1,7,8,11,13]*		

Essential Function		
<u>Family Involved Teaming</u> *A deliberate and structured approach to involving youth and families in decision-making through facilitated meetings of family members, their identified supports and professionals working with the family. Building a network of support with and for family members that consists of both non-professional and professionals, as needed, who work together to help family members meet their goals. Identifying and defining the roles of all teams within the larger support network. Collaborating and coordinating across systems with and for families. Recognizing and appreciating the strength and support that a family's community, cultural and other natural relationships can provide. Establishing shared commitment and accountability with family members and others taking on their roles and responsibilities, holding themselves and others accountable for meeting goals. Creating an environment for psychologically safe, open and honest communication with the family and their formal and informal supports, facilitating continuous dialogue about the quality of services and adjustments needed. Collaborating within individual and between all the various teams, involving all components of the family's support system at all levels. Respectful and meaningful collaboration with families (and community partners) to achieve shared goals.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
• **Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.** ○ Recognizes that the team members come from diverse places. ○ Collaboratively identifies a support network made up of teams of informal and formal supports and ascertains the specific roles that individuals on the team can play, over time, to strengthen and support the family. ▪ Informal support teams may include natural and extended family and cultural, community and/or Tribal, and other family identified supports. ▪ Formal support teams may include external support/service providers serving the family including therapists, counselors, life coaches, medical professionals, teachers/childcare staff, other State agencies etc. ○ Continuously convenes, engages and supports the family's formal and informal teams. ○ Engages in ongoing communication about confidentiality and the implications for inclusion of informal and formal supports at team meetings. ○ Demonstrates respect to caregivers by having candid discussions and developing shared understanding with caregivers about their rights, role and expectations as parents and tenants	• **Regularly facilitates critical thinking and discussion with the family and their team.** ○ Demonstrates clear understanding that team members come from diverse places but inconsistently specifies roles and how these may change over time. ○ Inconsistently convenes, engages and supports the family's formal and informal teams. ○ Sometimes engages in communication about confidentiality and the implications for inclusion of informal and formal supports at team meetings. ○ Develops a shared understanding with caregivers; though there may be missed opportunities to update this understanding over time. ○ Usually incorporates family strengths, resources, cultural perspective and solutions in all stages of the work, there may be gaps in documentation of these efforts. ○ Sometimes celebrates successes and accomplishments. ○ Documentation of results is inconsistent. • **Typically collaborates with CP&P and community partners.** ○ Usually maintains a minimum of once monthly contact (via telephone or in-person) with CP&P staff, *should the family have an open case.* ○ Sometimes networks with community partners but inconsistently involves them in planning meetings.	• **Planning discussions frequently include only the family and are often limited to the practitioner's perspective of challenges and success.** ○ Rarely identifies, or convenes, a broad support network and the roles they can play over time. ○ Demonstrates limited understanding of the importance of confidentiality and the implications for inclusion of informal and formal supports. ○ Often does not validate the caregivers' rights, role and expectations as parents and tenants. ○ Inconsistently incorporates family strengths, resources, cultural perspective and solutions in all decision-making, case planning, reports, meeting notes and other documents. ○ Frequently misses the opportunity to celebrate, and document, success and accomplishments. • **Collaboration with CP&P and other partners is sparse.** ○ Contact with CP&P staff typically occurs only during a crisis, *if the family has an open case.* ○ If often disconnected from community partners who are supporting the family.

○ Facilitates continuous dialogue with the family and their team members regarding how the agreed-upon supports and plans are working and reinforces the roles of the team members. ○ Incorporates family strengths, resources, cultural perspective and solutions in all decision-making, case planning, reports, meeting notes and other documents. ○ Celebrates success and accomplishments, no matter how small. ○ Supports the family's skill development in utilizing both formal and informal supports as a part of their team. ○ Documents results of communications used in practice and service adjustments. ○ Convenes the family to facilitate collaboration around the development of goals and implementation of services. ▪ In the case of reunification, the goal may be to obtain information (e.g., child's health, routines, discipline techniques) to support the child's transition home. • **Collaborates with CP&P and community partners.** ○ Maintains a minimum of once monthly contact (via telephone or in-person) with CP&P staff, *should the family have an open case.* ○ Networks with community partners to share ideas, expertise, challenges and solutions. ○ Involves community partners in planning meetings and considers their service recommendations, as appropriate, when goal setting and planning with the family. ○ Defines clear roles for each member of the team including CP&P and other collaborative staff so that all team members are working towards a common goal for the family. • **Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.** ○ Conducts family planning meetings which include: ▪ Discussing family's progress; ▪ Updating goals; and, ▪ Determining if changes in service intensity are appropriate.	• **Usually facilitates an established protocol for team meetings or attends team meetings regarding service planning.** ○ Frequently conducts family planning meetings. ○ Usually participates in CP&P case conferences, FTMs or other family meetings.	○ Sometimes will involve community partners in planning meetings but often dismiss their recommendations. ○ There are often missed opportunities to clarify team member roles. • **Rarely facilitates team meetings and the protocol is inconsistent.** ○ Rarely facilitates family planning meetings and often misses CP&P case conferences, FTMs or other family meetings.

○ Attends and actively participates in CP&P case conferences, Family Team Meetings (FTMs), and/or other child and family meetings, as needed and/or appropriate.		

Essential Function		
<u>Tracking and Adjusting</u> *Following up on the intervention delivery processes through regular communication with family members and service providers to understand progress being made, barriers encountered and changing family circumstances. Regularly updating service needs assessments and individualized service plans to reflect the changing service needs and goals of family members.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
• **Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.** ○ Creates and gathers progress assessments from all parties and reviews that information with families. ○ Identifies and resolves service delivery issues, overcoming barriers and adjusting strategies, as needed. ○ Facilitates adjustments to plans and services based on family and support team discussions, assessments, and decisions. ○ Understands and monitors family progress, identifies emergent needs and makes adjustments to plans when necessary. ○ Addresses known risks to reduce/avert crises. ○ Works with family to identify needs and attend to them in planning efforts with all team members. ○ Ensures safety plans are in place when needed. • **Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.** ○ Highlights contradictions and inconsistencies in the parent's behavior or stated goals, values, and self-perceptions. ○ Attempts to raise the parent's awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the parent.	• **Regularly establishes but inconsistently maintains communication with family members and their support team about the current plan.** ○ Creates and gathers progress assessments from all parties, however, only information is inconsistently reviewed with families. ○ Identifies service delivery issues but misses opportunities to resolve barriers and adjust strategies. ○ Usually facilitates adjustments to plans and services. ○ Understands and monitors family progress, but sometimes misses opportunities to identify emergent needs. ○ Inconsistently addresses known risks and safety plans. • **Inconsistently prompts the parent's increased awareness of a discrepancies.** ○ Misses opportunities to highlight contradictions and inconsistencies in the parent's behavior or stated goals, values, and self-perceptions.	• **Establishes sporadic communication with family members and their support team about the current plan.** ○ Does not gather progress assessments from various parties. ○ Rarely identifies or resolves service delivery issues. ○ Demonstrates limited understanding of the family's progress and rarely identifies emergent needs. ○ Often disregards known risks and safety plans. • **Seldomly prompts the parent's increased awareness of discrepancies.** ○ Rarely highlights contradictions and inconsistencies in the parent's behavior. ○ Often misses the opportunity to raise the parent's awareness of personal consequences based on their actions. ○ May avoid engaging the parent in a frank discussion of perceived discrepancies.

○ Engages the parent in a frank discussion of perceived discrepancies and help the parent consider options to regain equilibrium by asking the parent to: ▪ Look into the future and imagine a changed life under certain conditions (e.g., absence of drug abuse, if married with children); ▪ Look back and recall periods of better functioning in contrast to the present circumstances; and/or ▪ Consider the worst possible scenario resulting from their use or the best possible consequences resulting from trying to change.	○ Usually highlights contradictions and inconsistencies in the parent's behavior. ○ Engages the parent in a frank discussion of perceived discrepancies but doesn't always help the parent consider options to regain equilibrium.	

Essential Function		
Advocating and Educating *Speaking up for families and serving as a role model in order to support them in strengthening their family, meeting their needs, finding their voice and developing their ability to advocate for themselves. Coordinating with the family's formal and informal advocates to assist the family to find their own solutions. Encouraging, supporting and providing opportunities for family members to actively share their voice, offer solutions act as leaders and be central in assessment, planning and decisions about their lives. Helping families advocate for themselves and others for system and policy improvements. Supporting the development of increased knowledge and skills needed to follow through with the identified goals. These goals could include parenting, home management, mental health, nutrition, self-care, etc.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
• **Advocates on behalf of parents/families as necessary.** ○ Supports the family's interests and needs at schools, courts, social service organizations, etc. to ensure that the family's voice is heard. ○ Reframes other's expectations or ideas about the family and communicates the family's strengths. ○ Communicates with other service providers involved with the family (with family's written consent) by advocating on behalf of the family's strengths and current needs for support. ○ Understands assertive communication skills and when to best utilize these skills to advocate for the family's needs. ○ Links families with professional or peer advocates when requested and includes the family's support persons and advocates on the team. *[13,15]* • **Supports the family in advocating for themselves.** ○ Teaches families to advocate for themselves through modeling, role playing, and coaching. ○ Assists family members in identifying and voicing their concerns and needs through regular assessment. ○ Coaches families to advocate for themselves through modeling self-advocacy, problem-solving, persistence and supports them in navigating systems effectively. ○ Teaches family members assertive communication skills and encouraging them to utilize these skills. ○ Supports family members in developing and sharing their own stories and "lived experiences" by: ▪ Showing genuine interest; ▪ Utilizing reflective listening; and/or	• **Usually advocates on behalf of parents/families.** ○ Misses some opportunities to support the family's interests and needs with community partners. ○ Inconsistently reframes other's expectations or ideas about the family and sometimes communicates the family's strengths. ○ Limited understanding of assertive communication skills and therefore, misses opportunities to utilize these skills to advocate for families. ○ Usually links families with professional or peer advocates when requested. • **Typically supports the family in advocating for themselves.** ○ Usually teaches families to advocate for themselves through modeling, role playing, and coaching. ○ Inconsistently assists family members in identifying and voicing their concerns and needs through regular assessment. ○ Supports families in navigating systems effectively. ○ Sometimes supports family members in developing and sharing their own stories, "lived experiences" and feedback about processes and interventions that impact them. ○ Usually considers family members experts on their families.	• **Seldomly advocates on behalf of parents/families.** ○ Rarely supports the family's interests and needs with community partners. ○ Often reaffirms other's expectations or ideas about the family and does not communicate the family's strengths. ○ Demonstrates lack of understanding regarding assertive communication skills and how best to utilize it. ○ Sometimes disregards the family's request to be connected with other professional or peer advocates. • **Rarely supports the family in advocating for themselves.** ○ Infrequently teaches and coaches families to advocate for themselves. ○ Demonstrates lack of understanding regarding the role of regular assessment in helping families voice their concerns and needs. ○ Misses many opportunities to supports families in navigating systems effectively. ○ Seldom supports family members in developing and sharing their own stories, "lived experiences" and feedback about processes and interventions that impact them.

▪ Encouraging family members to share experiences during FTMs when comfortable. ○ Considers family members experts on their families. ○ Encourages and supports family members to give input and provide feedback on processes and interventions which impact them. *[1,3,7,8,15]* • **Promotes macro/system's level advocacy.** ○ Considers family members as the experts on the KFT program by asking for consistent feedback and taking concerns seriously. ○ Encourages and supports family members in taking leadership roles and ownership in the program. ○ Provides opportunities for families to participate in organizational and system level advocacy through providing information on who they can contact and encouraging them to write letters, make phone calls, complete surveys, and participate in community events related to these systems. ○ Supports families in identifying and advocating for positive system and policy changes in their community by providing information on who they can contact and encouraging them to write letters, make phone calls, complete surveys, and participate in community events related to these systems. *[13,15]* • **Educates and supports skills development with families.** ○ Utilizes strategies requiring direct action/activity by the participant to practice the development of skills or acquisition of knowledge. ○ Adapts communication style to the needs of different participants, depending on their age, culture, ability, and learning style. ○ Provides educational material prior to meetings, when appropriate, and explains it in terms that are both accessible and meaningful to the family members. ○ Researches the local housing market and available community resources. ○ Demonstrates resourcefulness and creativity in planning interventions and teaching skills to families using various methods (e.g. use of therapeutic videos, games, handouts, worksheets, crafts, etc.).	• **Inconsistently promotes macro/system's level advocacy.** ○ Considers family members as the experts on the KFT program but inconsistently asks for feedback. ○ Typically encourages and supports family members in taking leadership roles and ownership in KFT. ○ Inconsistently presents opportunities for families to participate in organizational and community level changes. • **Typically educates and supports skills development with families.** ○ Usually utilizes strategies requiring direct action/activity by the participant to practice the development of skills. ○ Often adapts communication style to meet the needs of different participants. ○ Provides limited educational material prior to meetings, and often explains material it in terms that are meaningful to the family. ○ Typically researches the local housing market and community resources. ○ Demonstrates limited resourcefulness and creativity in planning interventions. ○ Provides limited information on how family members can increase their knowledge and skills in various topics areas (i.e., tenancy rights and landlords' engagement). ○ Typically empowers but may miss opportunities to teach families how to access community resources independently.	○ Often considers themselves (the practitioner) experts on the family. • **Frequently disregards the family's role in macro/system's level advocacy.** ○ Rarely solicits the family's feedback or take concerns seriously. ○ Does not encourage nor support family members in taking leadership roles and ownership in KFT. ○ Misses opportunities for families to participate in organizational and community level changes. • **Seldomly educates and supports skills development with families.** ○ Often uses communication styles that don't align with the needs of various participants. ○ Infrequently researches the local housing market and community resources. ○ Often struggles to demonstrate resourcefulness and creativity in planning interventions. ○ Sometimes inquiries about the family's progress but doesn't obtain feedback on the use of new skills. ○ Provides little to no information on how family members can increase their knowledge and skills. ○ Rarely empowers families to access community resources independently.

○ Inquires about the family's progress during follow-up visits and obtains feedback on use of new skills. ○ Makes accessible resources available to support the family (such as specific assistance funds, public library resources) to reinforce skill-based activities. ○ Provides information on how family members can increase their knowledge and skills independently. ○ Encourages and supports parents to incorporate and demonstrate skills they have learned or developed to meet the needs of their child(ren). ○ Educates families about their tenancy rights and responsibilities and relationship building with landlords. ○ Provides tenancy skills support (e.g. budgeting and bill payment, lease observance, housekeeping, social skills, relationship building to encourage positive interactions with landlords and neighbors). ○ Empowers families by teaching how to search for and access community resources they may need. *[2,3,5,6,7,13,15,16,18]*		

Essential Function		
Planning and Linking Services *Collaborate with family to develop appropriate family-centered/-driven goals that are attainable within identified timeframes. Without agreed upon goals and plans, families may only reach out when in crisis. Some common areas for goal setting in supportive housing include: Maintaining Housing (budgeting, physical maintenance, being a good neighbor etc.), Substance Use, Daily Living Skills, Legal Concerns, Vocation/employment, Education, Family/Parenting, Childcare/school, Leisure/socialization, Medical/health, Spirituality.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		
• **Assists the family in developing and executing a detailed service plan.** ○ Seeks guidance from the parent or acts as though sessions are a joint effort as opposed to one in which the practitioner consistently is in control by: ▪ Emphasizing the (greater) importance of the parent's perspective and decisions about if and how to change; and ▪ Making explicit statements that verbalize respect for the parent's autonomy and personal choice. ○ Facilitates discussion that includes the following areas: (1) the desired changes, (2) reasons for wanting to make these changes, (3) steps to make the changes, (4) people available to support the change plan, (5) impediments or obstacles to change and how to address them, and (6) methods of determining whether the plan has worked. ○ Identifies, in collaboration with family, two to four goals at a time with the intent to improve housing stability and family functioning. Each goal should have a minimum of 2-3 measurable objectives and interventions specific to the parent's needs. ○ Clarifies individual family member goals and collective family goals and attending to both. ○ Develops goals that are clearly delineated and defined in behaviorally specific language that are achievable within the identified timeframe. ○ Encourages open and ongoing dialogue and clarifies each family members desire for themselves versus imposing his/her own expectations for family members. ○ Elicits parent self-motivational statements or "change talk," or any type of discussion about change by:	• **Usually assists the family in developing and executing a detailed service plan.** ○ Seeks guidance from the parent but at times acts as though the practitioner controls the discussion. ○ Facilitates discussion about the stages of change and planning but may omit key points. ○ Usually collaborates with the family to identify two to four SMART goals at a time. ○ Clarifies individual family member goals and collective family goals but does not always attend to both. ○ Encourages open and ongoing dialogue but inconsistently clarifies each family members desire for themselves and at times imposes his/her own expectations for family members. • **Researches and connects families to community resources/supports to meet the family's needs.** ○ Typically utilizes specific assistance funding to support parents. ○ Provides referrals and information, but inconsistently uses a warm hand-off to confirm linkage. ○ Frequently connects and re-connects family members to formal and informal supports. ○ Usually supports and encourages caregivers in participating in activities unrelated to their role as a parent.	• **Inconsistently assists the family in developing and executing the service plan.** ○ Seldomly seeks guidance from the parent and acts as though practitioner is consistently in control of session. ○ Rarely facilitates discussion about the stages of change. ○ Often identifies more than four goals at a time, without the family's input. Goals are inconsistently SMART. ○ Seldomly clarifies individual and collective family goals. ○ Frequently imposes his/her own expectations for family members. • **Inconsistently connects families to community resources/supports.** ○ Often misses the opportunity to utilize specific assistance to support the family. ○ Occasionally facilitates referrals and information, but rarely through a warm hand-off. ○ Infrequently connects and re-connects the family to formal and informal supports. ○ Inconsistently supports caregivers in participating in activities unrelated to their parental role. ○ Discussion of potential barriers are often limited.

▪ Asking questions or making comments designed to promote greater awareness/concern for a problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change; ▪ Asking the parent about how other people view the parent's behavior as concerning or problematic and how these concerns by others impact the parent's motivation for change; and/or ▪ Initiating a more formal discussion of the stages of change or level of motivation by helping the parent develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened. In brief, capturing somewhat more directive means for eliciting a parent's change talk and addressing a parent's commitment to change. • **Researches and connects families to community resources/supports most closely suited to the family's needs.** o Utilizes specific assistance to parents funding and resources to meet the families' needs or alleviate stress. o Provides referrals and information, actively links families through in-person visits, attends meetings and appointments, and completes applications for services, etc. o Connects and re-connects family members to formal and informal services and supports, cultural practices and traditions that can assist them with healing and recovery and meeting other goals. o Supports and encourages caregivers in participating in activities unrelated to their role as a parent in efforts to promote self-care and managing stress o Explores potential barriers and coaches parent(s) on strategies to resolve. o Expresses confidence in the parent's ability to achieve his/her goals through affirming the parent by: ▪ Using compliments or praise; ▪ Acknowledging the parent's personal qualities, competencies or abilities that might promote change; ▪ Recognizing effort or small steps taken by the parent to change; and/or ▪ Using a positive reframe to affirm the parent (e.g., noting how multiple treatment episodes and numerous relapses are evidence of	o Sometimes explores potential barriers and coaches parent(s) on strategies to resolve. o Inconsistently uses affirmations to support the parent's confidence in achieving his/her goals.	o Rarely uses affirmations to encourage parents.

the parent's persistence in trying to deal with his or her drug use problems and not giving up).		

Essential Function		
<u>Clinical Intervening</u> *Purposeful use of evidence based/informed approaches intended to help families identify and process emotions and practice positive coping skills.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts		

• **Promotes behavioral change through clinical interventions.** ○ Consistently employs Motivational Interviewing techniques. ○ Uses trauma-informed therapeutic approaches to assist and support family members. ○ Uses clinical expertise to observe, document and evaluate parent-child interactions. ○ Addresses concerns and supports family goals with a focus on decreasing family conflict, improving communication, developing the parent's ability to manage child's behaviors and decreasing high risk factors within the family. ○ Directly intervenes with children and models parenting techniques and skills to promote healthy attachment and increased child wellbeing. ○ Assesses and normalizes child's coping skills. ○ Provides feedback and positive reinforcement on parenting skills and interactions. ○ Educates parents on child development. ○ Observes how the parent responds to and uses information provided and aligns frequency of intervening to parental needs and skills. ○ Empowers and allows parents to be the lead in caring for their children with support as needed. ○ Coaches' parents to meet the needs of their children, while being careful not to undermine their authority and confidence in their parenting role. *[1,3,11,15]*	• **Frequently promotes behavioral change through clinical interventions.** ○ Sometimes employs MI techniques and other trauma-informed therapeutic approaches to support the family. ○ Usually uses clinical expertise to observe, document and evaluate parent-child interactions. ○ Sporadically intervenes with children and models parenting techniques and skills. ○ Typically assesses and normalizes child's coping skills while addressing some concerns. ○ Provides some feedback and but misses opportunities to provide positive reinforcement on parenting skills and interactions. ○ Provides limited education to parents on child development. ○ Observes how the parent responds to and uses information provided but infrequently aligns the frequency of intervening to parental needs and skills. ○ Sometimes empowers the parent to be the lead in caring for their children. ○ Coaches' parents to meet the needs of their children, but at times may undermine their authority and confidence in their parenting role.	• **Rarely uses clinical interventions to promote behavioral change or employs intervention with low fidelity.** ○ Demonstrates insufficient understanding or mastery of MI and other trauma-informed therapeutic approaches. ○ Often avoids addressing concerns and misses opportunities to model parenting techniques and skills. ○ Inconsistently assesses and normalizes child's coping skills. ○ Feedback and positive reinforcement regarding parenting skills and interactions is vague and inconsistent. ○ Provides little to no education to parents on child development. ○ The frequency of intervening is consistently not aligned with parental needs and skills. ○ Rarely views the parents as the lead in caring for their children and provides little to no parental coaching.

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APPENDIX D
NJ KFT SERVICE DELIVERY FLOWCHART

NEW JERSEY KEEPING FAMILIES TOGETHER SERVICE DELIVERY FLOWCHART

REFERRAL AND PRE-ENROLLMENT

The DCP&P worker makes the initial referral on behalf of the family to the KFT local office liaison, often the DCP&P RDS. The KFT local office liaison partners with the KFT program lead (this person manages the KFT program within the DCF Central Office) to finalize referral information, complete the KFT screening tool and confirm the family's program eligibility.

If eligible, the KFT program lead notifies the KFT local office liaison and KFT Provider team to move forward with the initial case conference.

If ineligible, the DCP&P team assesses the family for alternate supports and resources.

INITIAL CASE CONFERENCE

The KFT Provider team completes the initial case conference with the DCP&P local office to gather additional background information (family's case history and any updates since the initial screening) to confirm the family's eligibility.

If eligible,the DCP&P case manager provides a referral packet (completed referral form, the family's case plan, and all supporting documents) to the KFT team.

The KFT Provider team discusses necessary forms/documentation and schedules ongoing communication with the DCP&P team to facilitate documentation gathering and next steps.

If ineligible, the DCP&P case manager notifies the family and moves forward with alternate support services. The KFT Provider team does make contact with the family if they are deemed ineligible during the initial case conference.

The KFT team contacts the family to schedule an introductory/enrollment meeting in partnership with DCP&P.

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INTAKE AND ENROLLMENT

The KFT Provider team meets with the family. The team explains the KFT program, informs the family of the process and completes an initial assessment of the family's immediate needs (this may include safety and other basic needs). The family decides whether they want to move forward with KFT services.

If yes, the KFT Provider team initiates services; Housing Case Management and Support Services.

If the family declines KFT, the KFT Practictioner notifies the DCP&P team; who will assess the family for alternate supports and/or resources.

HOUSING AND CASE MANAGEMENT SERVICES

The KFT Practitioner begins housing case management services with the family.

The KFT and DCP&P teams in collaboration with the family, complete a series of meetings/calls, and other communication, to complete the voucher application.

(This process includes gathering supporting documents for all household members).

The KFT Practitioner collects and emails all documentation to the KFT Supervisor, who submits the voucher application to DCA Central Office.

The DCA Central Office reviews the application packet for eligibility and completes required background check(s).

If the DCA Central Office denies the application, the KFT Practitioner informs the family and DCP&P team immediately.*

KFT team provides alternative housing resources and DCP&P supports the family in accessing alternate supports and programs.

*Note: all application denials should be disussed with the KFT program lead ahead of family notification.

When the application is approved, DCA central office notifies the local field office; who then notifies the family of approval and schedules a briefing meeting.

At voucher briefing meeting, the family receives the housing voucher and can now begin searching for housing. The meeting includes the KFT parent, DCA field office staff and the KFT Practitioner.

SUPPORT SERVICES

The KFT Provider team begins support services with the family.

Note, all KFT services are voluntary for the family though not for the KFT Provider team.

If the family agrees to services, the KFT Provider team completes corresponding assessments to guide service planning and delivery (i.e. standardized individual and family assessments).

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The KFT Practitioner assists the family with finding a unit in the community.

If a unit is not secured within the DCA required initial housing search timeframe (60 days), the KFT Practitioner submits a written request for extension on behalf of (or in collaboration with) the family.

Note: If housing is not secured within 120 days, the family runs the risk of losing the housing voucher.

After the family selects a unit, the KFT practitoner works to ensure the landlord receives all required forms from DCA (including the Request for Tenancy Form (RFT)). The KFT Practitioner works in partnership with the parent and landlord to complete and return the RFT, and other required forms, to DCA.

After receiving the RFT, the DCA team conducts an inspection of the unit.

If the unit fails, the DCA team provides the landlord with a list of deficiencies and the landlord is given 30 days to remedy the concerns. If the concerns are not addressed, the family works with the KFT Provider team to identify another unit.

When the unit passes inspections, the landlord and DCA execute a Housing Assistance Payment (HAP) contract.The landlord and parent also executes a lease agreement. Prior to move in, the KFT Practitioner supports the family with the security deposit (this may be from KFT funding and/or community based resources).

The family receives the keys to the unit and moves into their new home.

The KFT Provider team supports the family with moving in, furnishing the unit and settling into their new home.

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STABILIZATION AND MAINTENANCE

The KFT Provider team engages the family by offering an array of services that include: case management, in-home visits, therapeutic services (individual and family), group sessions and referral/linkage to community-based supports.

Note: all KFT services are voluntary for the family though not for the KFT Provider team. The frequency of service provision is guided by a variety of factors (including family need, readiness for change, etc.).

In addition to services, the KFT Provider team also coordinates the ongoing collaboration of system partners serving the family (including DCP&P, Board of Social Services, Juvenile Justice, etc.) to support housing stability and well-being.

SUPPORT SERVICES: HOUSING

The KFT Practitioner facilities housing services activities that consist of the following:

- ongoing tenancy supports including planning, housing search, security deposits, case management, landlord engagement, and eviction prevention.

SUPPORT SERVICES: WELL-BEING AND COMMUNITY CONNECTIONS

The KFT Practitioner facilities well-being and community connection activities related to behavioral health, healthcare, and linkages to social supports.

Specific activities may include:

- parent advocacy, crisis intervention, case management, transportation, clinical and peer support services, employment and career services.

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MOVING ON AND AFTERCARE

The KFT Provider team collaboratively plans with the family and their support network for transitions; whether to a new unit or transitioning from the KFT program. The KFT Practitioner supports the family throughout transitions: both planned and unplanned.

PLANNED TRANSITIONS

The KFT Practitioner works with the family to establish a timeline for pre-transition discussions to ensure tasks are being completed and barriers are addressed.

Pre-transitions tasks includes:

ensuring the family is in possession of pertinent documents (legal, medical, identification); has made any needed medical appointments and has signed releases of information; and identified new unit/housing.

The KFT Provider team provides referrals to community resources as needed.

The KFT Provider team celebrates the family's success and transition out of KFT with a warm hand-off to community based support. The KFT Practitioner completes a discharge summary that is documented in the case file.

The KFT Provider team facilitates aftercare support to the family for 3 – 6 months post-transition to ensure family stability, assess the adjustment to reduction in KFT services, and provide referrals to community based resources, if needed.

Note: the KFT Provider team may provide aftercare support beyond 90 days at their discretion. The alignment of family needs and staff resources may impact the agency's capacity to extend aftercare support beyond 90 days.

UNPLANNED TRANSITIONS

The KFT Provider team will make every effort to support the family in transition planning and identifying necessary resources.

Attempts include but aren't limited to:

unannounced home visits, sending letters to all known addresses, connecting with members of the family's formal and informal support network and other activities to engage the family.

The KFT Provider team makes every attempt to inform the family of how they can assist with appeals, grievances and the overall transition process.

The KFT Provider team continues all attempts to reach the family regarding aftercare support until all efforts have been exhausted; the family's voucher is formally terminated or there is confirmation the family relocated and the 90 day aftercare timeline is exhausted.

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APPENDIX E
NJ KFT PRACTITIONER—JOB DESCRIPTION

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: KFT Practitioner

DESCRIPTION: The KFT Practitioner is responsible for providing guidance, extensive support and resources to KFT families. This role includes "hands on" intensive case management support and includes the provision of the following services: conducting standard assessments, home visits, support throughout the housing process (including pre-application, housing search/navigation and ongoing tenancy support), linkage to community resources, facilitate provision of concrete services (this may include administering KFT specific assistance to clients funding, providing transportation etc.) and serve as a liaison between the family and formal supports (e.g., DCP&P and other entities). The title KFT Practitioner may encompass various roles such as the housing case manager.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.
- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.
- Continually assesses and updates the Service Plan at regular intervals.

Family Involved Teaming

- Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.
- Collaborates with CP&P and community partners.
- Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.

Tracking and Adjusting

- Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking Services

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

POSITION STATUS: Full-time (minimum of 40 hours/week),

REQUIREMENTS:

Education: Graduation from an accredited college or university with a bachelors degree in social work or other related area.

Experience: Minimum of three (3) years of work experience in mental health services; Experience working with diverse populations.

License: Required to possess a valid professional license and/or certification and a valid driver's license in good standing.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

APPENDIX F
NJ KFT CLINICIAN—JOB DESCRIPTION

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: KFT Clinician

DESCRIPTION: The clinician provides in-home therapy services for KFT families; this may include individual and family therapy as needed. Clinicians support families in identifying treatment goals and providing therapeutic intervention aligned with meeting the identified needs (e.g., mental health, substance use etc.).

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.
- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.
- Continually assesses and updates the Service Plan at regular intervals.

Family Involved Teaming

- Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.
- Collaborates with CP&P and community partners.
- Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.

Tracking and Adjusting

- Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.
- Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

Clinical Intervening

- Promotes behavioral change through clinical interventions.

POSITION STATUS: Full-time (minimum of 40 hours/week)

REQUIREMENTS:

Education: Graduation from an accredited college or university with a master's degree in social work, counseling or other related area.

Experience: Minimum of three (3) years of work experience in mental health services; Experience working with diverse populations.

License: Required to possess a valid professional license and/or certification and a valid driver's license in good standing.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

APPENDIX G
NJ KFT PROGRAM MANAGER—JOB DESCRIPTION

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: Program Director/Manager/Supervisor

DESCRIPTION: The KFT Program Director/Manager/Supervisor is responsible for the overall daily operation and implementation of the KFT program. This may include recruiting, hiring/selection, coaching, supervising, data collection and reporting, participating in CQI activities and delivering presentations. The KFT Program Director/Manager/Supervisor is also responsible for providing, or coordinating, clinical oversight for appropriate staff.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.
- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.
- Continually assesses and updates the Service Plan at regular intervals.

Family Involved Teaming

- Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.
- Collaborates with CP&P and community partners.
- Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.

Tracking and Adjusting

- Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.
- Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking Services

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

Clinical Intervening

- Promotes behavioral change through clinical interventions.

POSITION STATUS: Full-time (minimum of 40 hours/week)

REQUIREMENTS:

Education: Graduation from an accredited college or university with a master's degree in social work or counseling or other related area.

Experience: Minimum of three (3) years of work experience in mental health services; Experience working with diverse populations.

License: Required to possess a valid professional license and/or certification and a valid driver's license in good standing.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

APPENDIX H
NJ KFT INTERVIEW PROTOCOL

Keeping Families Together Interview Protocol

The following resources are designed to support Keeping Families Together (KFT) programs with the recruitment, hiring and selection of staff. The resources represent implementation science best practices as well as existing NJ DCF resources to ensure a consistent process for recruiting and selecting competent staff who will be responsible for implementing KFT.

While there are a number of interview materials and resources that Provider teams should review in developing a recruitment and selection protocol. This interview protocol is intended to supplement additional resources Providers teams may already be utilizing.

The current resource includes the following:

- Two sets of interview questions for use during initial phone screenings and follow up in-person interviews. These questions can be modified as needed if the Provider team will not conduct two stages of interviews (phone and in-person) or for the specific position. It is strongly suggested teams reviews the questions ahead of an interview, identify relevant questions and customize questions as needed.
- Mock case studies, scenarios and behavioral rehearsals. These provide opportunities to assess the candidates' skills beyond the interview questions. The team should decide which of these activities to use, and at which point during the selection process.
- *Note*, the agreed upon protocol should be used consistently with all candidates, and the team should use a standardized scoring rubric to assess each applicant.

Table of Contents

[1] Cohen, C.; Gimein, T.; Bulin, T. & Kollar, S. (2010). *Real Cases: Integrating Child Welfare Practice Across the Social Work Curriculum.* New York City Social Work Education Consortium & New York City Administration for Children's Services.

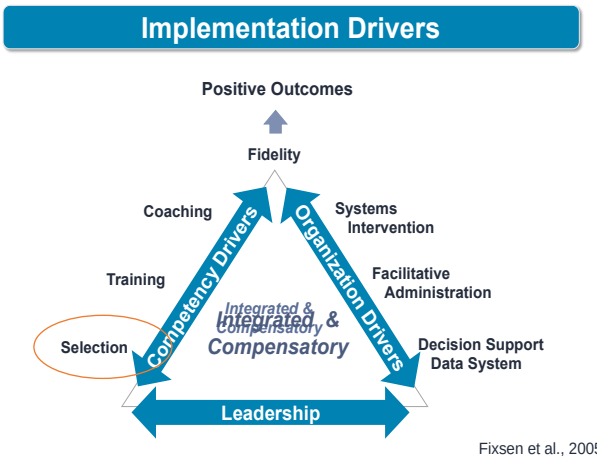
Implementation Drivers Tip Sheet

NIRN NATIONAL IMPLEMENTATION RESEARCH NETWORK

Supporting Effective Implementation of KFT Practice Profile: Recruitment and Selection

Implementation drivers refer to the key infrastructure elements needed to support practice, organizational, and systems change necessary for successful implementation of the Keeping Families Together program. Implementation Drivers collectively support fidelity to the KFT intervention. These drivers include competency, organization and selection.

Competency drivers (selection, training and coaching) speaks to developing and improving KFT program's staff competencies to internalize and use the guiding principles and essential functions in the KFT Practice Profile consistently.



Fixsen et al., 2005

Organization drivers (facilitative administration, systems interventions and decision-support data systems) create the hospitable organization and systems environments that are needed for KFT to be implemented as intended and achieve the expected outcomes.

Selection drivers refer to the use of a purposeful process for recruiting and hiring KFT program staff with the required skills, abilities, and other specific prerequisite characteristics to implement the KFT intervention. Staff selection from an active implementation perspective is different from selection as usual.

- *Selection is viewed as a mutual process*. The KFT program decides whether or not to select or hire an individual *and* the process allows the applicant to understand expectations related to the position, so they may decide whether the position is a good fit for them.
- *Selection assesses for essential staff characteristics, including those that are tough to teach, in order to set staff up for success*. Effective staffing requires the specification of required knowledge, skills, and abilities that relate to program-specific needs. This means specifying skills and abilities that are pre-requisites for the work ahead and determining those that will be developed once the person is hired. The selection process provides the opportunity to select for specific traits or characteristics – ones that may be challenging to support through training and coaching. For example, characteristics such as being flexible may be relevant to staff within KFT programs. Information gathered through the selection process can be fed forward to directors,

trainers, and coaches to help them understand the strengths of the person and more quickly focus on areas that may need attention.

- *Selection sets clear expectations for new hires*. The selection process uses job postings and interviews to lay clear and specific expectations for KFT program staff's new role. For example, a clear expectation for the role may be understanding the value of coaching and being willing to use coaching to assure fidelity.

Considerations for using the KFT Practice Profile for Recruitment and Selection

The KFT Practice Profile is a detailed document that outlines the guiding principles and essential functions of the day-to-day practice of the KFT program staff and was developed with full participation of the KFT Provider network. The **guiding principles** refer to the philosophies, principles, or beliefs that staff have when working with community individuals and families. While **essential functions** refer to the components that must be present to say that the practice exists and detail what is done when working with families. The job descriptions listed in Appendix A are aligned to support the KFT Practice Profile. Note, additional guidance on best practices for hiring and selection are provided below.

Best Practices for Recruitment and Selection

1. **There is someone accountable for the recruitment and selection of relevant staff for the KFT program.**

   A specific person is responsible for coordinating the quality and timeliness of recruitment and selection processes for KFT staff. This person is able to execute the responsibilities related to his/her role in the selection process.

2. **Job descriptions are in place for relevant staff who implement the KFT intervention.**

   Job descriptions are:
   - clear about expectations for the position; and
   - aligned with the competencies required for the KFT Practice Profile to be done well.

3. **Individuals accountable for selection understand the skills and abilities needed for relevant staff.**

   Individuals accountable for selection:
   - know the knowledge, skills, and abilities related to the staff position; and
   - accurately assess applicant knowledge, skills, and abilities.

4. **Selection protocols are in place to assess competencies for relevant staff who implement the KFT intervention**

   Selection protocol includes all of the following:
   - an assessment of core skills needed for position;
   - specific procedures (e.g., scenario, role play) for assessing individual ability to perform key skills;
   - specific procedures for assessing ability to receive and use feedback provided during the interview;
   - a documented process for review of adherence to the interview protocol; and
   - record of the ratings of individuals' responses.

5. **Selection processes are regularly reviewed.**

   Selection processes are annually reviewed and revised as needed to improve the selection process. The annual review examines at least three of the following:

- interview results (e.g. protocol adherence, applicant responses);
- training data;
- turnover data;
- fidelity data; and/or
- exit interview results.

KFT Practitioner/Clinician Initial Telephone Interview

Instructions for Interviewers:

1) Introduce Agency

2) Describe KFT and position, including work location (county and hours (nights, weekends, holidays, etc.) and salary range, benefits, etc.; verify licensing/certifications; let applicant know that her/his driver history abstract and background checks will be requested (including child abuse record inquiry – CARI)

3) Ask the candidate if after explaining a little more about the job and the requirements he or she is still interested in the position. If not, thank the candidate and end the interview. If yes, move on to the initial telephone interview questions below.

4) Ask the following initial telephone interview questions:

- *What motivates you to work with families, particularly those involved with the child welfare/child protection system?*
- *Tell me about your experience working with children and families. Do you have experience working with families involved with the child welfare/child protection system? Do you have experience working with families or individuals with substance use concerns, mental health concerns, and individuals experience housing instability?*
- *This position requires working with families in the community and in their homes – how do you feel about that? Is that something you feel you're able to do?*
- *Are you able to work a varied and flexible schedule to meet the needs of families?*

5) Let the candidate know if he or she is selected to move forward with the interview process, the next step is a face-to-face interview which would include a behavioral rehearsal (role play) and mock case study (writing sample) and ask if the candidate has any questions.

In-Person Interview Questions (Following the Initial Phone Interview)

General Assessment Interview Questions

- What is it about this job that attracts you? Please talk about what motivates you to work with families, particularly those involved with the child welfare/protection system.
- What led you to apply for this position at this time? Describe your professional journey thus far and your future professional aspirations.
- Describe how your past experience might help you in this position and make you a good fit.
- What strengths do you feel you would bring to this position?
- What areas do you think you may need support or professional development in for this position?
- Describe your organizational skills. How do you manage a busy schedule?
- What qualities do you like to see in a supervisor and how do you like to be supervised?
- How do you handle conflicts on the job (with coworkers, supervisors or families)? Describe a particular difficulty that you had on your last job and how you handled it.
- Have you ever been asked to do something unethical or unprofessional? If so, describe the situation and how you handled it. If not, how would you handle that type of situation?
- Is there anything else that you think would be important for us to know about you?
- Do you have any questions for us?

Essential Function Focused Questions

Engaging

- What are some best practices for staying connected to families you are working with? How would you create an environment where all family members feel a part of the service?
- Describe how you have worked with families from various different backgrounds?

- What is your comfort level regarding working in the community and in families' homes? Are there specific aspects you may be uncomfortable with? How do you usually manage these aspects?

Assessing

- How would you best gather information from or about a family to better understand roadblocks to goals?

- Do you have experience conducting assessments with families? Have you used standardized assessment tools? If so, what tools have you used?

Family Involved Teaming

- Can you provide an example of a time that you helped develop supports for a family you worked with?

- Can you discuss the importance of utilizing formal and informal supports in building a team around a family? Give an example of a time you had to partner with a community agency.

Tracking and Adjusting

- Families we support are often in transition and/or have changing circumstance, have you supported a family through transition or change? What strategies did you use?

- How would you discuss a discrepancy between where a parent is, and where they want to be?

Planning and Linking

- Do you have experience creating a service plan with families? Or experience setting clearly defined goals?
- Is it important to ask for input from a family when linking to a community resource? If so, how would you best identify a program that meets the needs of the family?

- Do you have experience working in the identified county? Are their service providers that you are familiar with or have worked with in the past?

Advocating

- How important is it for families to advocate for themselves? What are ways you've supported a family who struggles to advocate for themselves? Can you describe a time you had to advocate for a family?

- As you advocate on a family's behalf, how will you handle situations where other parties (CP&P, community provider, etc.) might have differing opinions about a family's best interests?

Clinical Intervening (Clinicians Only)

- For KFT Clinicians, what clinical skills and interventions have you used, or will use, with the families? Please describe your experience supporting families with substance use risk factors.

Behavioral Rehearsal/Role Play

Instructions for both KFT Practitioners and Clinicians:

Situation: DCP&P Permanency Worker referred Alicia, 23yo single mother of 9-month-old, Lizzie, to KFT. At the time of the referral to KFT, Alicia had been in a substance use treatment program for 5 months. She has a history of using opiates and is currently on suboxone. Alicia is very open to assistance from KFT and she is participatory but guarded.

Alicia expresses that she has not been able to successfully maintain a job for any considerable period of time and when she has, she has not been able to manage finances. She has been homeless or unstable, often living in and out of various friend's houses. Alicia states that after she had Lizzie, she was very open to help and that having a daughter "woke her up".

Roles: The candidate will play the role of the KFT Practitioner/Clinician. The interviewer will play the role of the parent.

Instructions for Interviewers: Listen for ways the candidate supports the parents and child in this scenario and works with the family to address concerns and plan for next steps.

Listen for: Engaging, Assessing, Family Involved Teaming, Advocating

Following the Role Play: The interviewers should ask the candidate to rate her/his performance during the role play activity and ask the candidate what he/she thought went well and areas he/she could have improved. Interviewers should listen to and consider how the candidate reflects on his/her performance and how that aligns with the interviewers' assessment. The interviewers should provide constructive feedback and ask the candidate what he/she might have done differently with the information offered. Interviewers should

look for the candidate to be open and responsive to the feedback and be thoughtful about how he/she would have responded differently with the insight.

Mock Case Studies/Writing Sample

A. Instructions for KFT Practitioner/Clinician:

Instructions to the Candidate: Based on the behavioral rehearsal/role play, please document your interactions with the family in a brief progress note.

Instructions for the Interviewer*:* Completed progress note should be a well-written, easily understandable description of the role play interactions.

Interviewers should review the completed progress note and focus on: Accuracy, Clarity, Conciseness, Coherence, and Spelling and Grammar.

B. Instructions for KFT Practitioner/Clinician:

Instructions to the KFT Practitioner/Clinician:
Based on the case study[2] provided please write a clinical impression (Clinician) or case summary (KFT Practitioner) for the identified family. Candidates should "consider the range of information available, any interesting or troubling omissions or contradictions in the facts the CPS worker was able to gather, your case assessment, the subsequent service recommendations you would make, and any glaring deficiencies in the larger service and/or policy environment highlighted by this case,"[3]

Instructions for the Interviewer*:*
Interviewers should present one of the case studies attached in Appendix A to the candidate. After the candidate completes the clinical impression, the interviewers should review and score *only the items discussed during the interview.*

[2] [3] Cohen, C.; Gimein, T.; Bulin, T. & Kollar, S. (2010). *Real Cases: Integrating Child Welfare Practice Across the Social Work Curriculum.* New York City Social Work Education Consortium & New York City Administration for Children's Services.

Candidate Scoring Rubric

Candidate Name:					
Job Position Applied for:					
Interviewer Name:					
	1 *unsatisfactory*	2 *satisfactory*	3 *average*	4 *above average*	5 *exceptional*
Telephone Interview					
Interest in position					
Related experience and qualifications					
Communication skills					
Invite to In-Person Interview?	*Recommended*		*Not Recommended*		
In-Person Interview, Behavioral Rehearsal and/or Mock Case Study					
General Assessment					
Engaging					
Assessing					
Family Involved Teaming					
Tracking and Adjusting					
Planning and Linking					
Advocating					
Clinical Intervening (Clinicians Only)					
Behavioral Rehearsal/Role Play					
Assessing skills					
Problem solving skills					
Active listening skills					
Ability to accept feedback					
Mock Case Study/Writing Sample					

Communication and writing skills					
Critical thinking skills					

Candidate's Strengths:	
Candidate's Weaknesses:	
Additional Notes/Comments:	
Final Recommendation	*Recommended* *Not Recommended*

Appendix A: Sample Case Studies (3) for Mock Case Study/Writing Sample

Real Cases Project: The Case Studies[4]

ANDREA R. CASE STUDY

Case Details

Borough: Queens
Type of Report: Initial
Date of Intake: 9/15/07
Source of Report: Hospital psychiatrist
Date of Initial Visit: 9/15/07
Date Source Contacted: 9/15/07

Current Allegation: Inadequate Guardianship

Household:
Mother, Andrea R., age 27
Son, Vincent, age 9

Other Family Members:
Father, John S., age 33
Sister, Elizabeth, age 29

Allegation: Psychiatrist from Elmhurst Hospital called saying the mother overdosed on Zoloft last night and was brought to the hospital at 6:30 A.M. She was accompanied by her 9 year old son, Vincent. She was admitted to the hospital, but refused to give any information to assist in making a plan for Vincent.

Family Background

Andrea is a 27 year old Caucasian woman who lives with her 9 year old son, Vincent in a one bedroom apartment in Queens that is described as spacious and clean. She is unemployed and receives $23 daily in food stamps, $68.50 biweekly in cash, and $624 monthly for SSI due to Vincent's autism/chronic asthma. Vincent's father is 33 year old, and is unemployed. He receives SSI due to an accident that occurred when he was 14 and left him unable to use his arm. John provides Andrea with occasional financial support and is involved with Vincent, visiting him 3 times a month. Both Andrea and John report having positive experiences with each other.

Andrea has been hospitalized at least 3-4 times according to her sister. She has been diagnosed at different times with schizophrenia, bi-polar disorder, major depression, and epilepsy. She currently takes Zoloft and seizure medication.

[4] Cohen, C.; Gimein, T.; Bulin, T. & Kollar, S. (2010). *Real Cases: Integrating Child Welfare Practice Across the Social Work Curriculum.* New York City Social Work Education Consortium & New York City Administration for Children's Services.

Prior Investigations

There have been five prior reports dating from 2001 to January 2007 against this family. In January 2001 an anonymous source reported Andrea for corporal punishment, inadequate guardianship, and drug and alcohol misuse. It was noted that Vincent communicated by crying, yelling, and making loud noises. After investigation and evaluation of the boy by an early intervention program, he was referred to a specialized hospital program and the case was closed, unfounded.

In November of the same year allegations of inadequate guardianship, lacerations, welts and bruises were made against Vincent's father John. The allegation was first made by a police officer to whom Andrea complained after her son returned home from a visit with his father with a black and blue mark under his eye. A social worker at the hospital where his mother took him for treatment made the same allegation. The father claimed that the bruise resulted from Vincent falling off a bed and onto a toy. Andrea said that he had returned from other visits with bruises so she became suspicious. The doctor who saw Vincent at the hospital did not think the bruise could have occurred as a result of an accident, and that it had to be deliberately inflicted. However, after an extensive investigation including several home visits, and interviews with the boy, his father, his paternal grandmother, with whom John lives, the doctor, and Andrea, the worker concluded that he "did not obtain any evidence to confirm the allegations." The case was closed, unfounded.

In 2002 a social worker at the preschool Vincent was attending made allegations of inadequate guardianship and inadequate food, clothing, and shelter against Andrea. It was alleged that Vincent often seemed uncared for, goes to school without extra diapers, in clothes that are often dirty or stained, and misses a day of school a week. Also, Andrea has usually failed to call the school when he was ill. The precipitating event for the report to the State Central Registry was that a teacher had to put another child's pamper on Vincent because his mother had not sent any extras, and he was wearing the same diaper for 36 hours. Andrea claimed that the diaper incident resulted from miscommunication with a friend who assists her so she can attend school. She forgot to ask her friend to change her child, and she does not change his pamper when he returns from school. The worker concluded that Andrea lacked knowledge of the child's developmental needs and referred her to a preventive service agency for services. The case was indicated.

The next report was made in 2006 by Andrea's ex-boyfriend's mother, who alleged parental drug and alcohol misuse and inadequate food, clothing, and shelter. Andrea denied the allegations, but said she knew who made the report. She had been assaulted by her ex-boyfriend, he was arrested, and she obtained a full order of protection against him. The CPS worker spoke with the district attorney, a friend who corroborated the assault against her, and the AHRC where Vincent was receiving services. All supported Andrea's story so the case was closed, unfounded.

The most recent complaint was filed by a police officer in January 2007. He reported that Andrea had become irrational, displaying extremely abnormal and erratic behavior, walking in circles, running from room to room, and calling 911 while officers were still in the home. He thought Vincent was also displaying abnormal behaviors similar to his mother. They were both transported to a major hospital where Andrea remained for about 2 weeks. During that time his maternal aunt, Elizabeth, cared for Vincent. Andrea was released with a diagnosis of major depression with psychotic features and prescribed several medications. She was to be seen by a therapist at the hospital so the case was closed, unfounded.

In addition to these reports, Andrea lived with her mother when at least 2 reports were made naming her and her siblings as maltreated. The allegations were educational neglect, lack of supervision, and inadequate guardianship. These complaints were filed when Andrea was 14 and 16. In both cases the sources complained Andrea's mother smoked crack, left the family alone when she went to buy drugs, and let Andrea and her sister be out on the street until late. In the later complaint it was also noted that different men were frequently seen going in and out of the house. Although both cases were indicated, it is unknown what services were provided.

Current Investigation

On 9/15 the source, Dr. H., a psychiatrist, told CPS that Andrea was brought to the hospital by EMS at 6:30 am that morning because she overdosed on Zoloft the night before. Andrea's son Vincent accompanied her to the hospital. Andrea took the medication in an attempt to kill herself because she was depressed, lonely, and overwhelmed, along with having conflict with both internal and external family members. Dr. H. also reported that Andrea was hospitalized for schizophrenia in January 2007 at another hospital. Andrea was described as being "alert, quiet, guarded and uncooperative," the latter because she failed to give the hospital staff any legitimate telephone numbers of resources for her son while she was being treated at the hospital. He asked that ACS make immediate plans for care of Vincent. The worker talked with Dr. H. about respite care as an alternative to foster care, but after consultation with a hospital administrator, it was decided that ACS should assume responsibility for Vincent.

The worker held a face-to-face interview that day at the hospital with the child, Vincent, a fourth-grader, who reported that he does well in school. During the interview, Vincent told the CPS that his mother was "nice and taking good care of him." He denied that his mother hit him and said that his mother would talk with him when he would do something bad. Vincent added that he had been helping his mother to clean the home since she was not feeling well. In reference to the suicide attempt, Vincent said that he saw his mother take medication, but did not know the reason. The interview concluded by Vincent telling the CPS that he helped his mother a lot and hoped that she would be better soon. The worker also attempted to interview Andrea, however, she did not appear coherent.

During the hospital visit, the worker again spoke with Dr. H., the source. He said that Andrea was admitted to the Emergency Unit for evaluation. He also told the worker that Vincent's maternal aunt, Elizabeth said that Andrea had been hospitalized over five times for psychiatric problems and that the family is concerned about Vincent's safety. According to Dr. H., the aunt did not feel that Vincent would be safe returning home to his mother until there was remarkable improvement in her mental condition.

On 9/16, Vincent was observed at the hospital and found to have no bruises or marks; he was removed to the Children's Center awaiting placement with a relative after the completion of an expedited home study. He was later placed with a voluntary foster care agency.

The CPS worker had a face-to-face interview with Vincent at the Children's Center on 9/17, during which Vincent said that he was home with his mother at the time of the incident. He said that he saw his mother drinking "black water", but he later said that it was "black pills." Vincent said that he was afraid his mother was going to turn into a monster, but he did not elaborate as to what he meant, even after the worker questioned him. After being asked how he is punished at home, Vincent said that his mother tells him not to do whatever he did again, and she has also told him that "I'm going to punch you in the

face." Vincent denied his mother ever followed through. He did admit to being hit by his mother 4 times with a belt on his arms and legs. When asked by the CPS whether he has ever seen his mother acting "weird or out of place," Vincent denied that his mother heard voices or talked to herself. He did however, say that his mother feels better when he takes care of her when she gets sick, and he clarified his mother's sickness as when she "gets a cold or when she doesn't feel good."

Vincent also explained that he makes his mother feel better by listening to her, watching television and being quiet. Asked about his father, Vincent said he sees his father on a regular basis. He likes to see his father because they go to the movies and the park.

The CPS observed an old scratch mark on Vincent's forehead and an old circular quarter-sized mark on his right arm. Vincent explained the mark on his forehead came from a fall while playing, but he did not have an explanation for the mark on his arm; he denied that it was the result of being hit. Vincent receives speech, counseling, and occupational therapy at his public school, where he is in special education.

On 09/17 the worker also had a face-to-face meeting with Andrea in the hospital, where she seemed heavily sedated. When the worker asked her about the incident that led to her hospitalization, Andrea reported that she took too many Zoloft, but did not know how many. She went on to explain that she took the pills because she was lonely and depressed. She said she called 911 after taking the pills so that EMS could take her and Vincent to a "different location."

Andrea said that she was seeing a psychiatrist named Dr. B., but she did not know how long or what his telephone number was. She denied hearing voices and past suicide attempts. She admitted she was hospitalized in Virginia while visiting a relative in May or June, but she refused to talk about it. Andrea said she takes Zoloft and Dilantin for her past diagnoses of depression and seizures, but she has not taken the medications on a regular basis. When asked how long ago it had been since she took the medication, Andrea responded by repeating herself. She asked to have Vincent placed with her sister, Elizabeth who reside in Brooklyn. She reported that she does not get along well with her mother or sister; and she hadn't seen them in over a month. She also stated that Vincent's father is involved because he brings her money.

An interview was held with Vincent's father John S., on 09/17 after the worker received a phone call from him. Mr. S. said that heard from Andrea that morning advising him that Vincent was placed in foster care. The worker explained that Vincent was at ECS because his mother overdosed on pills. Mr. S. said he was aware that Andrea had mental problems, but did not know how bad. He said that he had never lived with Andrea, and she appeared "fine" when he would see her. He said he only became aware of her mental problems recently, and Vincent never told him about any problems he was having at home or about any of his mother's unusual behaviors. Mr. S. was not aware of Andrea's prior hospitalizations. Mr. S. Said Vincent is his only child, and they have a close relationship. He visits his son three times a month, and he has always found him well groomed. He denied ever seeing marks on Vincent. When asked by the worker whether he was willing to care for Vincent, he refused because of his living conditions, which he would not further explain. He thought it would be best for Vincent to be placed with his aunt, Elizabeth.

The worker interviewed this maternal aunt, Elizabeth on 09/17 by telephone. She disclosed that Andrea was diagnosed a few years ago with schizophrenia, bipolar disorder, depression and epilepsy. Andrea was reportedly under the care of a psychiatrist at that time, but Elizabeth did not have any contact

information. She said Andrea attempted suicide and was in the hospital for at least a month in May or June.
At that time, Elizabeth said she cared for Vincent. Elizabeth further reported that Andrea had three or four more hospitalizations for the same reason, all occurring within a year. She could not give details of those hospitalizations. Elizabeth described Andrea as being unstable because of her mental health problems. She said the last time she saw Andrea was in July '07, and she had seen her crying and laughing at the same time. She also saw her talking to herself and hearing voices; however, she did not know what Andrea was saying. Elizabeth said that she has witnessed this behavior before. Vincent was described by Elizabeth as being very protective of his mother, saying nothing negative about her. Although Elizabeth disclosed that she is not close to her sister and hardly talks to her, she wants to be a resource for Vincent.

In exploring this possibility, the worker found that Elizabeth lives in a two-bedroom apartment with her husband and two children. She told Elizabeth that a visit would have to be made to her home to conduct a home study prior to Vincent's placement there. At that point, Elizabeth told the worker of prior ACS investigations, all of which were unfounded. She explained that these unfair reports were made by a woman in her building.

The worker also contacted Vincent's maternal grandmother, who said that she visits Andrea and Vincent on a regular basis. The worker discovered that this grandmother is not a placement resource because she currently lives in a rented single room. The grandmother said she witnessed Andrea "acting weird" only once when she was laughing and crying all at the same time, but she never questioned her about her behavior. She denied that Andrea talked to herself and was hearing voices, or that she abused drugs and alcohol. She described Andrea as being very loving towards Vincent so she never considered him in danger while in his mother's care. When asked whether Vincent ever talked to her about his mother's behavior, she denied this. She too described Vincent as being "very protective" of his mother. She said she never felt Vincent was in any danger with his mother.

On 9/18 the worker contacted Vincent's school and spoke with his teacher for the past two years. She said that Vincent had been attending the school for the past three or four years and is in a special education program under District 75. She added that Vincent does have an IEP on file from about three years ago, which states that Vincent is diagnosed with autism. He has not displayed behavioral problems and is in a regular education, but he receives speech therapy, counseling and occupational therapy. She also stated that there was no prior suspicion of abuse or neglect and that he has good grades and attendance.

On 09/18 the CPS worker filed an Article X petition against Andrea and a remand was granted. Vincent's father did not appear in court as he had previously promised. The case was adjourned to 10/11.

On 09/20, the CPS called Vincent's father to ascertain why he had not gone to court and to inform him about the next court date. Mr. S. said he had gone to court but he was late. He said he would show on 10/11. He was then asked if he could provide the names of any relatives that could be a resource for Vincent if maternal relatives should not be accepted. He said he did not have any in mind, but he would call back if he thought of any.

On 09/26, the CPS worker received a phone call from the psychiatrist, Dr. H, at the hospital where Andrea had been admitted. He said Andrea was discharged from inpatient psychiatric unit on 9/25 and was diagnosed with major depressive disorder and prescribed Zoloft. Andrea was also diagnosed with a

seizure disorder and was prescribed medication for this condition as well. The doctor recommended that Andrea continue to see the psychiatrist she had seen previously as an outpatient.

On 10/1 a 72-Hour conference was held at the foster care agency with the child evaluation specialist (CES), the unit supervisor, the supervisor and a worker from the foster care program, a worker from Association for Help of Retarded Children (AHRC), and Vincent's parents. During the conference Andrea produced her discharge form from the hospital recommending that she follow up at the other hospital with her psychiatrist, Dr. D. She said she had been seeing the psychiatrist for about a year. It was reported that Vincent was doing well in his program at AHRC where he was learning daily living skills and receiving after school care, and community integration services. In discussing plans for Vincent, Andrea could name only her sister, Elizabeth, and her mother as possible resources for Vincent, but she requested that neither be allowed to have contact with him without going through her. John said he thought Vincent should return to his mother's care. The conference ended with Andrea being advised that she must attend therapy weekly and also attend a parenting skills class.

On 10/11 both parents went to court where Andrea requested a 1028 hearing for Vincent. She produced a letter from her therapist, Dr. D., stating that she is being treated for major depressive disorder and has been compliant with therapy. Dr D. recommended that Vincent be reunited with his mother, writing that Andrea is capable of caring for her son.

On 10/12 the CPS worker made a home visit and met with Andrea. She noted that they lived in a clean, spacious one-bedroom apartment.

Andrea visited Vincent at the foster care agency on 10/13. Both were happy to see each other, and Vincent asked when he could go home with his mother. She explained to him that she couldn't make any promises. The foster care worker described them as having a strong positive bond and relating well to each other.

In another court hearing on 10/15 Andrea withdrew her 1028 request and asked for unsupervised visits with Vincent based on Dr. D's letter of recommendation. The foster care worker said the visit at the agency had gone well. The judge ordered the CPS worker to contact Andrea's psychiatrist, saying the case would be recalled.

That same day the worker called Dr D. who confirmed that he had been seeing Andrea for 2 years, found her to be generally compliant, taking her medications as prescribed. Noting that the doctor had not seen Andrea for several months prior to 9/28 when he wrote the letter for her, the CPS worker asked if he was aware that Andrea had a "mental breakdown" and was hospitalized for this on 1/7, 5/7 and 9/15. The doctor said he was aware and still recommended reunification.

The worker then asked if the doctor was aware that when Andrea took the handful of Zoloft, she did this in the presence of her son. The doctor was unaware of this, but did not change his position. He informed the worker that Andrea's condition would worsen if Vincent remained in care, saying she would become more depressed without him. He did not believe Andrea posed a risk to the safety of Vincent. He had seen her several times since her hospitalization and reported that she had been compliant with her 30 minute sessions. When the worker asked why he thought Andrea had not shown up for treatment for several months before this recent hospitalization, the doctor responded, "she just stopped coming." He added that when he saw her on 9/28, Andrea just said she was on "some sort of a trip." The doctor then ended the call, saying he was extremely busy, and disconnected.

When the case was recalled in court later that month, the CPS worker informed the judge that Andrea's psychiatrist had not seen her for several months prior to writing the letter. The judge then adjourned the case until 2/6/08 and ordered that all visits be supervised.

Real Cases Project: The Case Studies[5]

ANNE M. CASE STUDY

Case Details

Borough: Bronx
Type of Report: Initial
Source of Report: Social worker, Douglas Hospital
Date of Intake: 7/16/07
Date of Initial Home Visit with Subject: 7/17/07
Date Source Contacted: 7/17/07

Current Allegation: Inadequate Guardianship

Adults:	Anne Taylor M, b. 5/11/75, mother
	Peter M, b. 11/9/69, father
Children:	Thomas, b. 3/15/01
	Megan, b. 2/20/04

Allegation: Social worker from the hospital that treated Ms M. for injuries resulting from the beatings inflicted on her by her husband during their vacation in Jamaica is concerned about mother's capacity to care for and protect children.

Children were present during father's attacks on their mother.

Family Background

Anne M. is 32 years old woman employed for the past year as a secretary, earning about $30,000 a year. She has been married to Peter M. for 7 years. They have two children, Thomas, aged 6, and Megan, aged 3. Peter is an insurance agent who earns approximately $70,000 a year. Peter and the 2 children are all U.S. citizens. Anne, who was born in Jamaica, is a permanent resident of the US. Peter's family is also from Jamaica, but he was born in the City. They are both Episcopalians. Since the DV incident and subsequent return to the States, Mr. M. has been living in an apartment he co-owns with his mother in Brooklyn.

There was no prior ACS contact with this family, but a search of Domestic Incident Reports at the Police department revealed two prior domestic violence incidents in which Mr. M. was named as the suspect in 12/2002 and 10/2003.

Current Investigation

[5] Cohen, C.; Gimein, T.; Bulin, T. & Kollar, S. (2010). *Real Cases: Integrating Child Welfare Practice Across the Social Work Curriculum.* New York City Social Work Education Consortium & New York City Administration for Children's Services.

In the morning of 7/17 child protective service (CPS) worker left phone messages for both Mr. and Ms M. stating her name, contact number, agency, and need to schedule an appointment. Mr. M. returned the call at 2:00PM. When the CPS said she was conducting an investigation, he asked what the investigation was about and whom did it involve? The worker responded that she represented ACS and it was necessary for her to meet with him to discuss some safety concerns involving his children, Thomas and Megan. He explained that he was now living in Brooklyn, but he could be in the Bronx on Friday and agreed to a morning appointment at the worker's office.

Since Ms. M. did not return the call, the CPS made an unannounced visit to her apartment at 6:00 PM on 7/17. She was not at home, but the super agreed to take an envelope for her and said she should be home in 15-20 minutes. The worker waited and Ms M. and the children appeared shortly. When the CPS explained the purpose of her visit, Ms M. said she was planning to get the children dinner at Burger King and then go to Mr. M.'s apartment with the assistance of the police to serve her husband court papers for a temporary Order of Protection. She asked if the interview could take place at the restaurant. The worker replied yes, but a home assessment would have to be scheduled for the following day. Ms M. said she was very nervous about losing her job, but agreed to a 6:30 AM home visit on 7/18.

Subject's Account of Allegation

Ms M. said her husband inflicted bruises on her on 7/10 in the presence of the children during their vacation in Jamaica. When the CPS asked what was going on between her and her husband when this incident occurred, Ms M. explained that an old friend of hers called the week after they arrived and offered to show the family around. Her husband gave the friend directions to the house where they were staying, but when he arrived, Mr. M. said he didn't want to go and offered to stay home with the children. They were gone for about 3 hours, but when they returned her husband pulled the friend out of thecar and assaulted him. He was then arrested and stayed one night in jail.

Several days later they got into an argument because he left no money for her when he went out alone, although he knew she needed to buy food for the dish she was cooking, and she was counting on his taking the children with him. When he came back, she yelled at him; he then came at her with a closed fist, saying he saw her friend's car waiting outside. He punched her repeatedly in the face, neck, shoulders and arms as he was shouting, "You're making a fool out of me" and "You ruin my vacation." She realized she was bleeding all over and there was blood on the walls and the floor. When she went into the shower, he continued punching her. He finally left, saying he was going to kill her friend.

She tried to call the police by dialing 999, but got no response so she ran with the children to an upstairs apartment. He came back and was banging at the door with a brick so she decided to open the door before he got any angrier. She saw a knife in his pocket, but he saw the one she was holding. When he yelled, "let's go at it," she dropped her knife.

Her husband picked the knife up and held her in a choke hold while the children were screaming. He then became very frustrated with the children, screaming at them to shut up. When they did not stop, he took off his belt and started hitting them very hard. She tried to stop him from beating the children by jumping in front of them where she was hit across the back, neck and waist with the belt.

At that point the police arrived, alerted by a neighbor that it sounded like someone was trying to kill a woman. The police reportedly told her that if she had her husband arrested, she would be too because it takes two people to fight. They also told her if she wanted to press charges, she would have to stay in Jamaica to present evidence, they didn't know for how long.

She was able to get a flight to New York City for herself and the children early the next morning, 7/15. That evening she sought medical attention for herself and the children. The triage nurse in the ER called the police who interviewed Ms M. and the children and observed the bruises. However, they said they could just keep a note on file. Because the incident occurred out of the country, they could not arrest Mr. M. They told Ms M. she should go to Family Court and get an Order of Protection for herself and the children.

On 7/16 Ms M. went to Family Court and obtained a temporary Order of Protection for the children, herself, the children's day care provider, baby sitter, and various family members.

Initial Home Visit

At the home visit, it was clear that this 2-bedroom apartment was clean, well organized and furnished, with plenty of food in the refrigerator, locks and guards on the windows, and smoke and carbon monoxide alarms. Ms M. was able to show the worker the children's vaccination records and said the children have no special medical or mental health needs. Since the children share a twin bed in the 2nd bedroom, the worker explained why this was not a good idea and said she would help Ms M. get a set of bunk beds for the children.

The worker looked at the medical report Ms M. was given. The doctor wrote that Ms M. had a perforated ear drum with nerve damage, possibly resulting in some hearing loss, as well as bruises over her right eye requiring some stitches.

The CPS worker observed the children for marks and bruises. Both of the children had visible welts on their backs and arms. Thomas reported that "daddy hit me hard there, and it still hurts. When I was going upstairs, daddy hit me on the back and I was crying so he hit me again." Megan said, "daddy hit me right there," pointing to the welts on her arm, "daddy did it." When the CPS asked her if she could tell her what happened, Megan put her hands over her ears and said, "don't talk, don't talk."

Ms M. described her fear about her husband entering the apartment, explaining that before entering the apartment she leaves the children standing at the front door and dials 911 on her cell phone; she leaves the number on ready, so it can be pushed in an emergency. She then does a walk through of the apartment to insure her husband is not there.

Safety Plan

The worker discussed safety plans with Ms. M. She recommended that Ms. M. gather all vital documents in one safe place, pack a change of clothes for her and the children, have sufficient cash available in case she has to move in a hurry, and identify a place she can go unknown to her husband. Ms. M. agreed to these suggestions, saying she will request the assistance of a friend she has known for many years and will arrange a code word so others will know to call the police immediately if she calls and is in danger.

Ms. M. had already obtained an Order of Protection, but since she had difficulty serving him, the worker suggested she hire a process server.

Ms. M purchased new locks for both doors and requested help in getting them installed. The worker agreed to this, but suggested she might want to explore the possibility of other apartments with her landlord. Ms M. said she is not willing to do that at the moment because she likes the apartment and the community and feels safe once she enters and locks the door from the inside.

Court Involvement

Because of the safety concerns, the worker checked with a legal consultant in the agency and was told to prepare a complete W865d. Once this was reviewed, it was decided there were sufficient grounds for a neglect petition (Article 10) against Mr. M. The worker completed a COI (Court Ordered Investigation) and the court date was scheduled for 7/20. At the initial hearing Ms M. was assigned an 18B lawyer, and the case was adjourned for a week.

Mr. M. refused to attend either court hearing. When he talked with the worker, he said a friend who works for ACS told him there was something wrong with this hearing. "What is this court date about?" When the worker explained the hearing involves the safety concerns ACS has about his children, he responded: "I know my wife must have reported that while we were on vacation, I hit my kids. She's angry and reported that I hit them in the US because she wants me arrested." When the worker asked if he could explain what happened, he said, "We went on vacation and she disrespected me by going on a date with another man... I was fighting with my wife and I took off my belt and hit my kids. I know I hit them, but I don't abuse my kids." The worker told him it was in his best interest to go to the court hearing. She also informed him that an Order of Protection has been issued, which means he must not contact them, go to their residence or the children's school. He is to make no contact and is to stay away from them.

At the 856 hearing on 7/20, the children were paroled to their mother on condition of weekly ACS supervision with announced and unannounced visits. Respondent father was to have supervised visitation with the children upon consent of the law guardian. And children were to be evaluated, especially for play therapy. (The children did not want to see their father at this time, but it was hoped they would be able to move beyond this incident once they were enrolled in therapy).

At the Article 10 hearing on 8/8, the earlier orders were continued. No decision was made because Mr. M. did not have an attorney; and the judge said he could not have a court-appointed lawyer because of his income. The hearing was continued until 8/20. When he appeared at this hearing, Mr. M. still did not have an attorney. The judge informed him if he appeared again without a lawyer, he would have to represent himself.

Ongoing Contacts

During the approximate 6 weeks after the initial investigation, the CPS worker had 3 visits with the family, made 3 additional unannounced evening visits but no one was home, and had numerous telephone conversations with Ms. M. and related others. The worker's supervisors reviewed her activities several times during this time. She also tried to arrange an Elevated Risk conference with a child evaluation specialist (CES).

This conference was never held because the CES worker was unable to work out a time with Ms. M. due to her work schedule and child care issues.

During this same period the CPS worker received at least 7 calls from Ms. M. Her calls involved checking on the phone number of the law guardian assigned to the children, requesting help with the children's day care fees because she wasn't sure her husband would pay, and reports of a couple of text messages she received from her husband. Also, since the department had provided mattresses and bunk beds for the children, several of her calls related to the fact that her daughter had a severe allergic reaction to the bed bugs in the new mattress. (The worker eventually arranged for replacement mattresses).

The worker's calls and visits were focused primarily on the children's welfare and response to the domestic violence incident. She also followed up to make sure Ms. M. had contacted the domestic violence program to which she had been referred. During her visit on 8/3 she talked with the children and then asked them to go play in their room. When the worker commented that Ms. M. must be concerned her husband was not following the Order of Protection, Thomas ran into the room and turned the TV up loud. When the worker asked why he had done this, he ran to his mother and put his head on the couch. His mother said that whenever his sister mentions daddy, he says "no more daddy" and turns the TV up loud.

The worker made a visit to the children's day care program to discuss the children's progress. She was told that there had been no real change in the children's behavior. When she learned that Ms. M. had only given a copy of the Order of Protection to the head teacher, she said that each teacher should have a copy and called Ms. M. to remind her she must give each person a copy in order to protect the children.

On 8/17 the worker met with the family and the children's maternal grandmother (whom Ms. M. had named as her main support) at the day care center. During that meeting Ms. M. said she wanted to look for a new apartment. She was very nervous about staying in her current home. Ms. M. told the worker she would like to get some counseling for herself because she keeps having flashbacks to DV incident in Jamaica. She is worried that the children may also be having flashbacks and thinks they should have counseling too. When asked what she does to relieve her anxiety, she said she prays.

On 8/17 in the evening, the worker met with the mother and the children at the home of the babysitter whom Ms. M. had hired to cover while she is looking for a new apartment. Although she still seemed very anxious, the children were reportedly doing well and
related comfortably to the worker.

Elevated Risk Conference

On 8/30 an Elevated Risk Conference was held with Ms. M, the worker, and a child evaluation specialist. They discussed the history of domestic violence in the family. Ms. M. said they had several incidents in the past when her husband would get very angry, bump her and put his finger in her face. Thomas would run into the middle of them and say, "Don't talk to my mommy like that." Mr. M. would then go to the apartment he shares with his mother in Brooklyn for the weekend. There were two prior complaint of domestic violence in 2002 and 2003 when Ms. M. called the police after fights in which he hit and choked her. However, the incident in Jamaica was the only one in which their father hurt the children physically in any way.

Ms. M. said Megan is very anxious to see her father and keeps asking to call daddy. She sometimes plays with toys and calls them daddy. She covers her ears if anyone gets loud. Thomas is willing to talk with his father, but he doesn't want to see him. Ms. M. wants her children to see their father, but she doesn't know how they can ever have a normal relationship.

She also mentioned that before the incident in Jamaica, they had a very close relationship with her husband's brothers and they are her children's godfathers. They haven't said anything to her since the incident, but she is afraid to have her children visit them because their father may be there.

The child evaluation specialist said it was very important to get Mr. M. involved in services such as anger management and batterers' counseling. The plan recommended was that the CPS worker would continue monitoring the family, make strenuous attempts to engage Mr. M, and follow up on the referral of Mrs. M. to a domestic violence program.

A formal supervisory review was held on 8/31. It was noted that Mrs. M. response to the domestic violence was more than appropriate. She was always focused on safeguarding the children and removing them from the potential for more damage. She is looking forward to becoming engaged with a preventive service program that can help her deal with the domestic violence and other family needs.

Real Cases Project: The Case Studies[6]

MARY S. CASE STUDY

Case Details

Borough: Manhattan
Type of Report: Initial
Source of Report: Mother
Date of Intake: 9/29/2007
Date Source Contacted: 9/29/2007
Date of Initial Home Visit: 9/29/2007

Current Allegation: Inadequate Guardianship

Adults: Mary S., maternal grandmother and legal guardian
Susan, biological mother

Children: Jason, 15 y/o

Case Details

Allegation: The boy's mother, Susan, alleged that Mary S., the boy's maternal grandmother and legal guardian, is physically abusive and intimidating to 15yr old Jason. Yesterday 9-28-07, she reportedly punched the adolescent in the face after she told him to clean his bedroom. This is not the first time Mary has used physical force to intimidate Jason. He is afraid of his grandmother, as she has threatened to shoot him if he ever hits her back. Also, the grandmother goes out of town for days at a time and does not leave Jason any money for food. The last time she left was on Saturday and she did not return until Monday. Mary does not make an alternate plan for Jason's care when she travels out of state."

Jason's mother, Susan, says she and her husband gave custody of him to her mother when she was 17 because they did not have any health insurance. Susan says she went to court and filed a petition to revoke her mother's guardianship and the next court date is October 26, 2007. However, she has to serve her mother the paperwork first. Susan says her mother is a retired New York State corrections officer, and she may still have her weapon."

Family Background

This African American family consists of the 53 year-old maternal grandmother, Mary; her 32 year old daughter, Susan; Susan's 15year old son, Jason; her 9 and 5 year old sons; her 43 year old companion, Stanley; and Stanley's 2 daughters, aged 13 and 18.

[6] Cohen, C.; Gimein, T.; Bulin, T. & Kollar, S. (2010). *Real Cases: Integrating Child Welfare Practice Across the Social Work Curriculum.* New York City Social Work Education Consortium & New York City Administration for Children's Services.

Mary is a retired corrections officer. She receives $6400.00/month in pension benefits and an undisclosed amount from disability. Mary has diabetes and high blood pressure and takes medication for the condition. Mary was granted legal guardianship of Jason in December 1992, when Susan was 17-years old. It was documented that Susan and Jason's father signed over guardianship to Mary, so that Jason could be covered by her medical insurance. Since that time, Jason has alternated between living with Susan and with Mary. Susan moved to Chicago while Mary continues to reside in NY. Jason's father is deceased; the cause of death was not mentioned.

In the summer of 2006, Jason asked to live with Mary and has resided with her ever since. Susan filed a petition in June 2007 for modification of guardianship that was awarded to Mary in 1992, but the case was dismissed because she failed to appear in court. In September 2007, she filed another petition regarding the matter of guardianship; the judge requested that ACS submit a COI (Court Ordered Investigation) by October 21, 2007.

A courtesy visit to Susan's home was conducted by Illinois Child Protective Services due to the COI request. Susan resides in Chicago suburb with Stanley, her two other sons and Stanley's two children. They live in a two-story home with three bedrooms. The home was equipped with carbon monoxide/smoke detectors however there were no window guards. Susan works at a grocery store and earns $650.00/bi-weekly. Stanley works at a hardware store and earns $800.00/bi-weekly. Stanley has a criminal background. During 1984-1989, he was arrested for attempted robbery, resisting arrest and possession of stolen property. He was imprisoned in 1989 and paroled in 1992.

Mary and Jason reside in 3-story private home in Upper Manhattan. The living room and kitchen are on the first floor. The worker observed food in the refrigerator. The family room Jason's bedroom, bathroom and laundry room are located on the second floor. Jason's room is equipped with a full size bed, dresser, desk and closet. Mary lives on the third floor, which has an office, bathroom and bedroom. The home, which is well kept and neat, is equipped with a smoke/carbon monoxide detector.

Jason is dark-skinned, slightly overweight, average height, and has a short haircut. He began a new Catholic high school this month. Mary pays the tuition for his school. He was reportedly left back in the 6th grade while residing with his mother due to excessive absences. Jason is active in sports and plays baseball. This past summer he participated in baseball camp, karate class and weight training. In addition, he attended tutoring for math and English, once a week. The CPS worker observed that he was free from marks and bruises. Reportedly, he has had no developmental delays or disabilities, and no mental health needs.

Current Investigation

The S. Family first became known to ACS on 9/29/07, at 6:06 p.m. when the mother of the alleged maltreated child filed a complaint with the State Central Registry. At 6:08 an Emergency Children's Services worker was assigned the case for intake. When the case was received, the CPS conducted family clearances in WMS, CCRS, ACRS+, LTS, and the SCR. It was noted that the alleged subject, Mary S. is listed in Connections as a foster parent.

CPS called the source of the report in Illinois to confirm the allegations. The source, the alleged maltreated child's mother, confirmed what was reported, and also informed the CPS that she filed a petition with Family Court to terminate the guardianship rights of Mary S. She told the CPS worker that she had her other two children in her care, she had not relinquished her parental rights of Jason, and

she is seeking to have him live with her again. She also disclosed that Jason often called her crying and told her that he fears his grandmother. Jason told her that Mary S. punched him in the face for not cleaning his room fast enough when he was asked to. She said this incident was not the first time Mary S. has used excessive corporal punishment while disciplining Jason. The source also disclosed that Mary S. has left Jason home alone for days at a time, the last incident having taken place the week before when she traveled to Boston without him. Mary S. reportedly left Jason without adult supervision and money for food. The source expressed her concern for Jason's safety and well being, because Mary S. is a retired corrections officer that might still have a gun in the home.

Later that evening on 9/29 at 11:21 p.m., another worker attempted an unannounced home visit to the case address, but was unsuccessful. The CPS worker attempted to make contact with anyone who might have been at the case address by repeatedly using the intercom that was located at the top of the stairs, as well as calling the home telephone number listed on the intake report.

The case was reassigned to the Manhattan field office the morning of 9/30 and assigned to a CPS worker who attempted an initial home visit at 5:00 P.M. There was no one home then, but the worker made face-to-face contact with the family at 7:30 AM the next morning, 10/1

nterviews

On 10/1/07, the CPS worker interviewed Mary and Jason at their home address. She explained the reason for the CPS visit and asked Mary to discuss her relationship with Jason. Mary began by saying that she and Jason get into conflicts because he does not listen. She stated that he did not clean his room or bathroom and did not do his homework when he was supposed to. Mary informed the CPS that she has had legal custody of Jason since his birth. She showed the CPS the court documents and the letters Jason's parents wrote to the court. Until 2004, Jason lived with Susan. In the summer of 2004, Jason visited her with his two brothers and stayed with her since that time. The worker inquired about the reason why he stayed, and Mary stated that Susan's boyfriend, Stanley, punched Jason in the stomach. Mary stated she does not like the way Stanley treats the children. She also said that all of the children wanted to stay with her, but Susan would not allow it.

Jason told her that Stanley had his older son get a knife and cut his younger brother on the back of the foot. He also told her Stanley knelt down and punched him in the face. The 9 year old reportedly saw a gun in Susan and Stanley's bedroom. She said she has told Stanley not to put his hands on her grandchildren. She asks her grandchildren if anyone has bothered them, but the children are "afraid to disclose any information." She feels Susan does not protect the children. Mary S. contacted the Child Protective Services in Chicago, but they did nothing.

Mary continued that she is very strict with Jason because she wants the best for him. She did not feel that that he would do well living with Susan. He was left back in the 6th grade because Susan allowed him to miss 34 days of school. Mary stated she lives for her grandchildren. Jason has his own phone and is allowed to speak with his mother at anytime. Mary said Jason's problem is that he is lazy and does not like to do what he is told. She sent Jason away to baseball camp last summer and had him participate in weight training.

The CPS worker asked Mary if she punched Jason in the face. She stated that she told him to clean-up, but got fed up with him and punched him in the face. The worker asked if she hits him often, and she said that she has hit him only five times in his life. She usually yells at him or takes things away. She

denied leaving any marks or bruises on him. She also denied hitting him with an object, but said when he was little, she spanked him with a belt. Mary told the CPS that she has diabetes and high blood pressure so she cannot get worked up. When the worker asked if they get along except for cleaning issues, she said yes.

Mary explained that she is trying to rescue Jason from being a deadbeat. He has no positive male influences, and she is trying her best to teach him dignity. She does not want to hurt him, she just wants him to grow up and be something. Mary admitted that she becomes hot headed when Jason does not listen. The worker asked if she thought Jason would benefit from counseling, and she stated she would be willing to accept services. Mary refused to provide her social security number and sign the HIPPA form, but she gave the contact information for Jason's physician.

The worker met with Jason and first asked him about his summer. He relayed the he attended baseball camp, karate class, and weight training. He also said that he has friends and speaks with them on the phone or when he goes outside. When asked if he likes his new high school, he said that he has made a lot of friends because of his involvement in sports. The worker asked Jason to describe his relationship with grandmother, and he said they get into disagreements because he does not do what he is told. He does not clean his room and bathroom when she asks. When the worker asked him if he liked living with his grandmother, he responded that he did, but missed his brothers. Asked if he wanted to live with his mother, he replied, "of course, what child doesn't." He continued that he wished he could live with both his mother and grandmother, but knew it was impossible. The worker asked why and he said "because they do not get along."

Jason informed the CPS that he saw his brothers in June for his birthday and graduation. He also stated that he went to Chicago for his spring break. He stated he speaks with his mother daily. The worker asked Jason if he was scared of his grandmother, and he said no. Asked how he is disciplined, he said that his grandmother yells and curses at him. She hit him recently because he did not do what he was told. When asked where he was hit, he replied that she punched him in the face. The worker asked Jason about the last time she hit him, and he said about a year ago. In addition, she has thrown a boot at him, and it hit him in the arm. The worker asked if his grandmother threatened him, and he replied that she told him she will shoot him if he hits her. The worker asked if she has a gun, and he said he did not know. The CPS asked if he ever stayed home alone and he said, 'no.'

The worker attempted to contact his mother, the source, but she was unable to reach her. She contacted the pediatrician, Dr. S, who confirmed that Jason was seen on 6/29/2007. Dr. S. stated Jason has been coming to his office since October 2004, when he moved in with Mary. He relayed that he has never seen any marks and bruises on Jason. The CPS asked Dr. S if he suspected that Jason was abused and he said, "no."

On 10/7/07, the CPS met the source, Susan, in court and spoke with her about the case. The CPS asked Susan to discuss the issues and she responded that Jason is constantly calling her stating he wants to come home. Jason has made continuous complaints about his grandmother cursing at him and not feeding him every day. Susan stated that she does not like what is going on. The only reason she allowed Jason to stay since 2004 was because he asked to, but now he hates his grandmother. The worker asked how she knew he was punched in the face, and she said he called her crying about it. She added that Jason had wanted to stay with his grandmother to complete junior high school and return to Chicago for high school. She is petitioning to terminate guardianship and that was the reason she was in court.

The worker received a message from Mary regarding the petition that Susan filed for custody. When she spoke with Mary in court, Mary said she does not want Susan to obtain custody. She feels that Jason will not have the same opportunities if he leaves. She just wants him to graduate from high school, and then he can do whatever he wants.

On 10/10, the CPS received a request for a Court Ordered Investigation that was due on 10/21/07. Also, the court ordered the Child Protective Office in Illinois to complete a home study. On 10/14, the CPS worker contacted Mary's sister, Dorothy E. and asked her to describe her sister as a grandmother. Dorothy stated that her sister is very caring, supportive and concerned for her grandchildren. She stated that she has never observed any marks or bruises on Jason. She said Mary and Jason are close, and he never said he was abused. Asked if she knew where Jason wanted to live, she replied probably with his mother because he misses his brothers. However, Dorothy believes that residing with Mary would be the best for him because he is more adequately cared for. The CPS asked Dorothy if Mary uses drugs and alcohol. Dorothy stated that Mary was a corrections officer and a role model for the family. The worker asked if she had any concerns for the child, and she responded that she is worried that all of these current issues may affect Jason psychologically.

The CPS worker contacted Mary's neighbor, Mr. B. to discuss his relationship with her. Mr. B. stated that he has been friendly with Mary for eight years. The CPS asked what Mr. B's perception of Jason was, and he relayed that Jason is a good and happy child. He stated that Mary is a good caretaker and takes adequate care of Jason. The CPS asked Mr. B. if Jason disclosed that he was abused and he replied no. Mr. B. stated that Jason had his phone number and was told if he needed to discuss male issues to contact Mr. B. Mr. B. denied having seen any marks or bruises on Jason. He denied any knowledge of Mary abusing drugs or alcohol. He stated that Mary keeps to herself and rarely has guests over to her home. The CPS asked if Mr. B. had any concerns for Jason and he said no.

The CPS worker called Diane G., a friend of Susan's for a reference. Diane said that she has been friendly with Susan for four years. The CPS asked Diane how often she sees Susan's boys, and she said she sees them often. She said that the children appear happy and they were clean. Diane stated she has not observed any marks and bruises on the children. She felt the kids are well cared for. "Susan is a good mother, very caring, and always there for her children." Asked if she had ever met Jason, she said yes. Jason gets along well with his mother, and they are respectful towards each other. The worker asked if Susan misused drugs and alcohol, and she said no. Also, she stated that Susan did not have people coming in and out of the home.

The CPS contacted Tara J., another friend of Susan's. Tara said that she has known Susan for two years. She does not see the children often, but she speaks with Susan often. Tara denied knowing of any drug/alcohol use. She has never observed any mark or bruises on the children. Tara stated that Susan is very good with her children so she does not have any concerns. She feels that Susan could care for all the children including Jason. She said she has never suspected any abuse and thinks the children are well taken care of.

On 10/19 the worker made an unannounced visit to Mary's home. She asked Mary how things have been going. She responded that Jason has been doing well in school thus far. Mary denied that Jason was acting any differently since their last court date. She said he has been his normal self. Mary told the worker that they return to court on 10/26, and she will let the judge make the decision. She would not fight the decision, but she is still not in agreement with Jason living with his mother. She wants what is best for him, but does not feel that it is with his mother.

The worker spoke with Jason about school, and he said it was fine. Asked if he was worried about the court matter, he said that he did not feel his grandmother and mother should be in court. “They should settle it within the family.” Asked what he wanted the outcome to be, he stated that he wanted to go with his mother. He misses his brothers and his mother. The worker then asked how he felt about his grandmother, and he said he felt the same. He knows that his grandmother just wants him to make something out of himself and that she had his best interest in mind. He denied having any recent arguments and being hit by Mary. The worker asked when he last spoke with his mother, and he said the night before. Asked how he felt when he spoke to her, he said that he was happy but sad when he would hang up.

The CPS asked Jason if he liked Stanley, and he said yes. Jason stated that he was nice and that they get along. Asked if Stanley ever hit him, he said yes. On one occasion Stanley punched him in the face because he was not listening. Another time, Stanley punched him in the chest, in the presence of his mother “for being smart to him.” His mother did not say anything because he was being disrespectful. When the worker said to Jason, “and you still like him,” he replied, yes, because Stanley provides for him and his brothers. Also, Stanley buys food and clothes for them. He stated that Stanley is like a father figure since his father died.

The CPS asked if Stanley ever hit his brothers, and he said they have gotten a few spankings. They were hit with a belt. Jason then described an instance where Stanley beat the 9 year old because Susan was too upset. He was beaten for two minutes because he stole money from his mother’s bag. Asked if his mother hit him, he said yes, but only on serious cases. He was spanked a few times, but usually his mother talks to him or takes something away from him.

On 10/21, the CPS worker submitted the COI to the Manhattan Family Court. On 10/28/07, the CPS left a message for Mary regarding the outcome of the court hearing.

Appendix B: KFT Job Descriptions

The following KFT job descriptions were developed for core KFT positions:

- KFT Practitioner
- KFT Clinician
- KFT Program Manager

These job descriptions are aligned with the KFT Practice Profile's guiding principles and essential functions. KFT providers may use these job descriptions as a guide for recruiting and hiring staff. They may modify position status (fulltime/part-time or per diem), and minimum requirements as applicable to meet agency's requirements and/or staffing needs.

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: KFT Practitioner

DESCRIPTION: The KFT Practitioner is responsible for providing guidance, extensive support and resources to KFT families. This role includes "hands on" intensive case management support and includes the provision of the following services: conducting standard assessments, home visits, support throughout the housing process (including pre-application, housing search/navigation and ongoing tenancy support), linkage to community resources, facilitate provision of concrete services (this may include administering KFT specific assistance to clients funding, providing transportation etc.) and serve as a liaison between the family and formal supports (e.g., DCP&P and other entities). The title KFT Practitioner may also include roles such as: housing specialist, employment specialist, etc.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.
- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.
- Continually assesses and updates the Service Plan at regular intervals.

Family Involved Teaming

- Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.
- Collaborates with CP&P and community partners.
- Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.

Tracking and Adjusting

- Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking Services

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

POSITION STATUS: Full-time or part time (minimum of __ hours/week)

REQUIREMENTS:

Education: Graduation from an accredited college or university with a bachelor's degree preferably in social work or other related area. Five (5) years of relevant work experience may substitute for degree.

Experience: **T**hree (3) years of work experience in social work/human services preferred. Experience working with diverse populations.

License: Required to possess a valid driver's license in good standing.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: KFT Clinician

DESCRIPTION: The clinician provides in-home therapy services to KFT families; this may include individual and family therapy as needed. Clinicians support families in identifying treatment goals and providing therapeutic intervention aligned with meeting the identified needs (e.g., mental health, substance use etc.). KFT clinician roles may include substance use counselor, mental health counselor, etc.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.
- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.
- Continually assesses and updates the Service Plan at regular intervals.

Family Involved Teaming

- Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.
- Collaborates with CP&P and community partners.
- Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.

Tracking and Adjusting

- Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.

- Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

Clinical Intervening

- Promotes behavioral change through clinical interventions.

POSITION STATUS: Full-time or part time (minimum of __ hours/week)

REQUIREMENTS:

Education and Experience: Graduation from an accredited college or university with a master's degree in social work, counseling or other related area preferred; or possess an undergraduate degree and 2 years of experience providing services to families with complex needs.

License: Required to possess and maintain a valid clinical license and/or certification and a valid driver's license in good standing. Candidate must fulfill continuing education requirements to maintain licensure.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection

and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: KFT Program Manager

DESCRIPTION: The KFT Program Manager is responsible for the overall daily operation and implementation of the KFT program. This includes recruiting, hiring/selection, coaching, supervising, data collection and reporting, participating in CQI activities and other duties as necessary to support program implementation and sustainability. The KFT Program Manager is also responsible for providing, or coordinating, clinical oversight for appropriate staff.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Conducts the initial meeting with family in a private setting to build rapport and relationship, to encourage honest sharing and to learn about the family's immediate needs.
- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.
- Continually assesses and updates the Service Plan at regular intervals.

Family Involved Teaming

- Facilitates critical thinking and discussion with the family, and their team, about family needs, how they define challenges and what success looks like.
- Collaborates with CP&P and community partners.
- Facilitates an established protocol for team meetings or attends team meetings to discuss progress, support services and changes in services intensity.

Tracking and Adjusting

- Establishes and maintains regular communication with family members, informal supports and service providers to assess if and how the practices, services, supports and plans are working and make changes if needed.
- Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking Services

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

Clinical Intervening

- Promotes behavioral change through clinical interventions.

POSITION STATUS: Full-time or part time (minimum of __ hours/week)

REQUIREMENTS:

Education and Experience: Graduation from an accredited college or university with a master's degree in social work, counseling or other related area preferred; or possess an undergraduate degree and 5 years of experience providing services to families with complex needs.

License: Possession of a valid professional license and/or certification is preferred. A valid driver's license in good standing is required.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

Supplemental Job Descriptions

ABOUT KEEPING FAMILIES TOGETHER (KFT): The KFT intervention includes the provision of supportive housing services for a subset of families involved with the DCF's Division of Child Protection and Permanency (DCP&P). More specifically, this supportive housing intervention targets families experiencing homelessness or housing instability, whose children are at risk for out-of-home placement or are in out-of-home placement with a case goal of reunification, and who are facing co-occurring

challenges including but not limited to substance use disorders, medical and/or mental illness, domestic violence etc.

TITLE: Housing Specialist

DESCRIPTION: This description should reflect a modified version of the KFT Practitioner.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing phone and in-person contact with family.
- Initiates and maintains ongoing phone and in-person contact with CP&P and other stakeholders, as appropriate.
- Communicates in an open, honest, respectful and culturally sensitive manner.
- Consistently employs Motivational Interviewing techniques.
- Consistently uses a family-centered approach.
- Uses assertive (persistent) and creative outreach/engagement strategies to encourage families to participate in services.

Assessing

- Uses a process to gather information.
- Completes required assessment tools.
- Synthesizes information and completes service plan.

Family Involved Teaming

- Networks with community partners to share ideas, expertise, challenges and solutions.

Tracking and Adjusting

- Prompts the parent's increased awareness of a discrepancy between where they are and where they want to be.

Advocating

- Advocates on behalf of parents/families as necessary.
- Supports the family in advocating for themselves.
- Promotes macro/system's level advocacy.
- Educates and supports skills development with families.

Planning and Linking Services

- Assists the family in developing and executing a detailed service plan.
- Researches and connects families to community resources/supports most closely suited to the family's needs.

POSITION STATUS: Full-time (minimum of 40 hours/week),

REQUIREMENTS:

Education: Graduation from an accredited college or university with a bachelors degree in social work or other related area.

Experience: Minimum of three (3) years of work experience in mental health services, Experience working with diverse populations.

License: Required to possess a valid driver's license in good standing.

Required Knowledge, Skills and Abilities:

- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

APPENDIX I
NJ KFT QUARTERLY REPORT TEMPLATE

Introduction

DCF is interested in building a culture of quality with our provider partners. This process requires transparency, curiosity, and eagerness to learn; openness to failures as learning opportunities; and commitment to performance.

As a KFT grantee, you have developed a local level logic model, which captures the core activities of your KFT program. The purpose of this quarterly report is to begin tracking implementation of these activities as well as intermediate outcomes for the families being served. As you work to complete this report, please keep in mind this is a learning process and an opportunity to reflect on successes and challenges. The information you provide will also inform DCF efforts to support KFT programming statewide.

The Process

Step 1: DCF emails the quarterly report tool to each KFT grantee on approximately the last day of the quarter. Please refer to the Quarterly Reporting Schedule below for exact dates.

Step 2: KFT grantees save the quarterly report tool, enter data into the tool, and submit a completed quarterly report by uploading it to your myNewJersey account. Grantees will have approximately one month to complete and submit each quarterly report. Please refer to the Quarterly Reporting Schedule below for due dates.

Step 3: DCF uses quarterly report data to create annual reports for each KFT grantee as well as an annual overall program evaluation report.

The Quarterly Report

The Quarterly Reports consists of three tabs: Family Data, and Narratives. Each tab is described below:

- Family Data - KFT grantees are asked to submit information about services and intermediate outcomes for <u>each family</u> served during this quarter. Services data will be collected every quarter. **Please see the Family Data Instructions tab for additional information on when to complete the Intermediate Outcomes Survey.

- Narrative - KFT grantees are asked to submit brief narratives that describe their program's successes, challenges, and requests for technical assistance.

Quarterly Reporting Schedule

2021-2022 Reporting Timeframes					Agency Tab		Family Data Tab		Narratives Tab
	Reporting Period	Reporting Tool Sent to Provider	Report Due Date		Staffing and Systems Collaboration	Staff Competency	Services	Intermediate Outcomes	Narratives
Quarterly Report 1	July 1 - Sept 30	Oct. 1	Oct. 29		✔	✔	✔	✔	✔
Quarterly Report 2	Oct 1 - Dec 31	Jan. 7	Jan. 28		✔	✔	✔	✔ **	✔
Quarterly Report 3	Jan 1 - Mar 31	Apr. 1	Apr. 29		✔	✔	✔	✔	✔
Quarterly Report 4	Apr 1 - Jun 30	Jul. 1	Jul. 29		✔	✔ *	✔	✔ **	✔

* Complete the Staff Training questions in Q4 only.

**In Q2 & Q4, only complete the Baseline Intermediate Outcomes Surveys for newly enrolled families.

FAMILY DATA TAB - INSTRUCTIONS

Before you begin completing surveys, PLEASE NOTE:

1. If you are having trouble opening the surveys, ensure you have enabled macros.

2. The staff member entering family data should use the status table provided on this tab to keep track of data entry for each family in their program. Services data for each family will be collected every quarter. Data related to intermediate outcomes will be collected at baseline and then subsequently every six months.

3. You should only provide information for parents who are enrolled in the program and residing in the household. The surveys contain parent-specific questions and have space to capture information for a "Parent 1" and a "Parent 2." If there is not a second parent residing in the household, leave Parent 2 questions blank.

4. We strongly suggest completing a hard copy of each survey prior to entering this data electronically. The hard copy of the survey should be completed by the KFT staff member(s) who are most familiar with the family. If more than one KFT staff member is needed to complete the survey, they should complete the survey together. Each of these surveys has been provided to you electronically, so you may print out as many copies as you need.

5. You will NOT be able to save the information in a survey and return to it at a later date. You should have a hard copy of the completed survey in front of you and be prepared to complete the electronic survey in its entirety. If you close the survey form before hitting "Submit," the information you've inputted will be lost.

6. If you choose the "Submit" button, the information you've inputted will be submitted. If you hit the "Submit" button before you've fully completed the survey, you will need to reopen the survey and start again.

General Instructions:

Step 1: Review the "Family Data" tab containing a pre-filled list of all current families/clients in your KFT program. Provide updates for each column, if applicable (i.e. if a family was housed during the quarter, please provide a move-in date).

> **Discharged Families:** If there is a family on the list that has been discharged, please complete the columns "Discharge Date" and "Reason for Discharge".
> **New Families:** For families enrolled in this quarter, add the families to the bottom of the list, highlighted in yellow. For new families, complete columns "Family Name", "Case ID", "KFT Enrollment Date", "KFT Move-In Date" (if applicable), and "County".

Step 2: Choose a family and begin your survey completion. You must complete both a services survey and an intermediate outcomes survey for each family. The order in which you complete these surveys does not matter. See specific instructions on how to complete each survey below.

Step 3: Once you have completed a survey for a family and hit the "Submit" button, the survey form will close. You will be returned to the Family Data tab. Go to the "Status of Survey Completion by Family" table, and choose "Completed" from the corresponding drop-down box for that family.

Services Survey Instructions:

The Services Survey captures the KFT services each family received during this quarter including case management, clinical case management, groups, etc. Each of the areas included on this survey has been pulled directly from your logic model.

Step 1: Complete the family information at the top of the survey. You must enter the family's CP&P case ID and a CP&P person ID for each parent in the household.

Step 2: Respond to the questions in each area including Housing Case Management, Clinical Case Management, Groups, etc. Your responses in this survey will consist of both dropdown options and typed responses. If the response box has dropdown options, there will be a button on the righthand side of the box. You must click on this button (downward arrow) to access and select a dropdown option. If there are no dropdown options (no button), please type your response into the box.

Step 3: Review the survey to ensure you have completed all necessary questions. Once the survey has been completed in its entirety for the family, hit "Submit" at the bottom of the survey form.

Intermediate Outcomes Survey Instructions:

The Intermediate Outcomes Survey is an adapted version of the Arizona Self-Sufficiency Matrix. This survey (matrix) captures client self-sufficiency across a series of 21 domains including housing, employment, family income, healthcare coverage, life skills, parent-child relations, etc. Please refer to the training materials that have been provided for additional guidance on how to complete this survey (matrix).

Step 1: Complete the family information at the top of the survey. You must enter the family's CP&P case ID and a CP&P person ID for each parent in the household.

Step 2: Use the provided dropdown options to choose a response for each of the domains in this survey. Of the 21 domains in this survey, 9 are repeated to allow for parent-specific responses (Parent 1 & Parent 2), and 4 of these repeated domains also ask for a response regarding children in the household.

Step 3: Review the survey to ensure you have completed all necessary domains. Once the survey has been completed in its entirety for the family, hit "Submit" at the bottom of the survey form.

Services Survey Instructions:

The Services Survey captures the KFT services each family received during this quarter including case management, clinical case management, groups, etc. Each of the areas included on this survey has been pulled directly from your logic model.

Step 1: Complete the family information at the top of the survey. You must enter the family's CP&P case ID and a CP&P person ID for each parent in the household.

Step 2: Respond to the questions in each area including Housing Case Management, Clinical Case Management, Groups, etc. Your responses in this survey will consist of both dropdown options and typed responses. If the response box has dropdown options, there will be a button on the righthand side of the box. You must click on this button (downward arrow) to access and select a dropdown option. If there are no dropdown options (no button), please type your response into the box.

Step 3: Review the survey to ensure you have completed all necessary questions. Once the survey has been completed in its entirety for the family, hit "Submit" at the bottom of the survey form.

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The Intermediate Outcomes Survey is an adapted version of the Arizona Self-Sufficiency Matrix. This survey (matrix) captures client self-sufficiency across a series of 21 domains including housing, employment, family income, healthcare coverage, life skills, parent-child relations, etc. Please refer to the training materials that have been provided for additional guidance on how to complete this survey (matrix).

Step 1: Complete the family information at the top of the survey. You must enter the family's CP&P case ID and a CP&P person ID for each parent in the household.

Step 2: Use the provided dropdown options to choose a response for each of the domains in this survey. Of the 21 domains in this survey, 9 are repeated to allow for parent-specific responses (Parent 1 & Parent 2), and 4 of these repeated domains also ask for a response regarding children in the household.

Step 3: Review the survey to ensure you have completed all necessary domains. Once the survey has been completed in its entirety for the family, hit "Submit" at the bottom of the survey form.

FAMILY DATA

Welcome to the family data section of your quarterly report!

This section captures family-level information on the services each family received and how well they are doing in certain areas. This section includes two separate surveys – a Services Survey and an Intermediate Outcomes Survey – and a status table to track survey completion for each family.

Instructions:

Before you begin completing this section, please review the instructions provided on the Family Data Instructions tab. We strongly recommend that you print these instructions and have them readily available when completing this section.

Please note: The Services Survey must be completed every quarter. Please refer to the Family Data Instructions tab for instructions on when to complete the Intermediate Outcomes Survey.

HOUSEHOLD COMPOSITION AND STATUS OF SURVEY COMPLETION BY FAMILY

Family Name	Case ID	KFT Enrollment Date	KFT Move in Date	Discharge Date	Reason for Discharge	County	Are there any non-parent adults living in the household?	If yes, what is the non-parent adult(s) relationship to the parent(s)?	Services Survey - Status	Intermediate Outcomes Survey - Status
Add new families here										

PROGRAM NARRATIVE

Welcome to the program narrative section of your quarterly report!
This section captures information on your program's successes, challenges, and ideas for additional support during this quarter.

Instructions:
Please provide a brief narrative response to each of the areas below.

SUCCESSES:
Please share at least one success story or bright spot for one of your families or the program overall during this quarter.

CHALLENGES:
Please share any challenges, barriers, or frustrations experienced during this quarter. These may be related to systems, program implementation, family-specific issues, etc. Indicate whether you were able to address the challenges/barriers, and if so, discuss how.

TECHNICAL ASSISTANCE:
Please share your ideas for how we can best support your work.

FREQUENTLY ASKED QUESTIONS:

CONSIDERATIONS

What if I don't have a family's CP&P case ID?
You must enter the family's CP&P case ID when completing each of the surveys. If you do not have a CP&P case ID for one or more of your families, contact KerryAnne Henry at 609-888-7204 / KerryAnne.Henry@dcf.nj.gov or Stephanie Curran at 609-888-7024 / Stephanie.Curran@dcf.nj.gov with the name of the family or families. OSD can provide you with the appropriate CP&P case ID(s).

What if I dont' have a parent's CP&P person ID?
You must enter the CP&P case ID for each parent in the household when completing the services and intermediate outcomes surveys. If you do not have a CP&P person ID for one or more of your parents, contact KerryAnne Henry at 609-888-7204 / KerryAnne.Henry@dcf.nj.gov or Stephanie Curran at 609-888-7024 / Stephanie.Curran@dcf.nj.gov with the name of the parent(s). OSD can provide you with the appropriate CP&P person ID(s).

Should a paramour be included in the quarterly report as Parent 2?
You should only provide information for parents who are enrolled in the program and residing in the household. The surveys contain parent-specific questions and have space to capture information for a "Parent 1" and a "Parent 2." If there is not a second parent residing in the household, leave Parent 2 questions blank.

Should we report on children who reside with another parent?
You should report on all children who reside in the household.

What is the confidence assessment column used for in the Intermediate Outcomes Survey?
This component of the tool was design by the tool SSM development team Youth & Family Alliance dba LifeWorks of Austin, Texas. The purpose of the score is to provide an opportunity to acknowledge when accurate assessment may be difficult. For example, when a relationship with a client is in its early stages you may have access to partial information. Most of the time, your score should be —5, or —Very confident. However, this is the place to indicate if you do not feel confident in your assessment of the client's self-sufficiency. It is very important to provide an honest assessment of your confidence and that you complete this section for every domain.

I noticed that Not Applicable has been added as a response option for some of the Intermediate Outcomes Survey domains. When should I choose Not Applicable for these domains?
Not Applicable has been added as a response option for 3 domains on the Intermediate Outcomes Survey: Employment, Childcare, and Education of Client's Children. The Not Applicable option may only be chosen under the following circumstances:

Employment – if the adult is not employable due to disability or age (i.e., of retirement age/eligible to receive retirement benefits).

Childcare –if there were no children residing in the household during the entire reporting period (i.e., children were in placement). If there were children in the parent's custody and residing in the household during the reporting period, you must provide a response to this domain. When responding to this domain, if the parent is typically available 24/7 to care for the children (e.g., not working), consider the family's access to childcare in an emergency situation where the parent(s) might be temporarily unavailable to care for his/her children.

Education of Client's Children – if there are no children age 3 or older in the household. Responses shall take into account whether the child(ren) age 3 or older is enrolled in preschool and/or school.

SUBMISSIONS

I am trying to upload my quarterly report to the myNewJersey portal, but I keep getting an error message that says, "Files of this type may not be stored for retrieval." What should I do?

The KFT Quarterly Report you receive from DCF is a ".xlsm" file and must be saved in this format while you are completing it. This file format allows for the use of "macros," which are necessary to operate the surveys. However, this type of file format (.xlsm) cannot be uploaded to the myNewJersey portal.

Once you have a final, completed quarterly report (and all surveys have been completed), you will need to save the final version of your Quarterly Report as a .xlsx file prior to uploading it to the myNewJersey portal. To do this, go to "Save As," and choose "Excel Workbook (*.xlsx)" under "Save as type." We strongly encourage you to use a different file name when saving to be clear about which version can be uploaded (and to ensure you have both versions saved just in case).

What if I accidently submit an incomplete quarterly report?

If you submit an incomplete quarterly report, you will need to complete the quarterly report and submit it again by uploading the completed version to myNewJersey account. You should also email KerryAnne Henry- KerryAnne.Henry@dcf.nj.gov or Stephanie Curran - Stephanie.Curran@dcf.nj.gov to indicate that you will be resubmitting.

What if I accidently submit an incomplete Services Survey or Intermediate Outcomes Survey on the Family Data tab?

If you submit an incomplete survey or a survey with incorrect information, you will need to complete the survey again and resubmit. You should also update the status of the family's survey to "Multiple Submissions" in the status table.

HELP

Who should I contact for technical trouble shooting?

If you need assistance, please contact KerryAnne Henry at 609-888-7204 / KerryAnne.Henry@dcf.nj.gov or Stephanie Curran at 609-888-7024 / Stephanie.Curran@dcf.nj.gov .

NJ KFT Quarterly Report – Services Survey

CASE INFORMATION

DCP&P Case ID #:		Reporting Date (MM/DD/YYYY):			
Parent 1. First Name:		Parent 1. Last Name:		Person 1. DCP&P Person ID #:	
Parent 2. First Name:		Parent 2. Last Name:		Person 2. DCP&P Person ID #:	

SERVICES

Case Management (with Practitioner)

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in individual face-to-face case management sessions? ☐ Yes ☐ No	Did this person participate in individual face-to-face case management sessions? ☐ Yes ☐ No
If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter
If yes, how long on average did the face-to-face meetings last (choose one)? If no, skip this question. ☐ 30 minutes ☐ 1 hour ☐ 1.5 hours ☐ 2 hours ☐ More than 2 hours	If yes, how long on average did the face-to-face meetings last (choose one)? If no, skip this question. ☐ 30 minutes ☐ 1 hour ☐ 1.5 hours ☐ 2 hours ☐ More than 2 hours
Did this person participate in individual phone case management sessions? ☐ Yes ☐ No	Did this person participate in individual phone case management sessions? ☐ Yes ☐ No

NJ KFT Quarterly Report – Services Survey

Case Management (continued):

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	If yes, how often on average did they participate (choose one)? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

Clinical Services (with Clinician):

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Has a treatment plan been completed? ☐ Yes ☐ No	Has a treatment plan been completed? ☐ Yes ☐ No
If yes, has the treatment plan been reviewed this quarter? If no, skip this question. ☐ Yes ☐ No	If yes, has the treatment plan been reviewed this quarter? If no, skip this question. ☐ Yes ☐ No
Did this person participate in individual face-to-face clinical/therapy sessions? ☐ Yes ☐ No	Did this person participate in individual face-to-face clinical/therapy sessions? ☐ Yes ☐ No
If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter	If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

NJ KFT Quarterly Report – Services Survey

Did this person participate in substance use treatment services? (Services may be provided by the KFT Provider or external partner.)	Did this person participate in substance use treatment services this quarter? (Services may be provided by the KFT Provider or external partner.)
☐ Yes ☐ No	☐ Yes ☐ No

Clinical Services (with Clinician) (continued):

Child(ren):
Did any child(ren) participate in individual face-to-face clinical/therapy sessions? ☐ Yes ☐ No
If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter
Family:
Did this family participate in face-to-face clinical/therapy sessions? ☐ Yes ☐ No
If yes, how often on average did they participate? If no, skip this question. ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Once a Quarter ☐ Twice a Quarter

Groups:

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in any program groups? ☐ Yes	Did this person participate in any program groups? ☐ Yes

☐ No	☐ No
If yes, how many group sessions did this person attend during the quarter (write in)? If no, skip this question. _____	If yes, how many group sessions did this person attend during the quarter (write in)? If no, skip this question. _____

Professional Development/Employment Services:

Parent 1:	**Parent 2** (leave blank if no Parent 2)**:**
Did this person participate in professional development/employment services? ☐ Yes ☐ No	Did this person participate in professional development/employment services? ☐ Yes ☐ No
If yes, for how many sessions during the quarter (write in)? If no, skip this question. _____	If yes, for how many sessions during the quarter (write in)? If no, skip this question. _____

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

CASE INFORMATION

DCP&P Case ID #		Reporting Date (MM/DD/YYYY):		Is this the Baseline Intermediate Survey for this Client? Y or N	
Parent 1. First Name:		Parent 1. Last Name:		Parent 1. DCP&P Person ID #	
Parent 2. First Name:		Parent 2. Last Name:		Parent 2. DCP&P Person ID #	

INTERMEDIATE OUTCOMES

Directions:

1. Use the Outcome Status Column to indicate your perception of the family's status for each domain. Provide a score of 1 through 5 based on the scale options provided. "Not applicable" is also a response option for the following domains and may only be selected when:

- Employment – the parent is not employable due to disability (unable to work/eligible to receive disability benefits) or age (of retirement age/eligible to receive retirement benefits).
- Childcare – there were no children residing in the household during the entire reporting period (i.e., children were in placement).
- Education of Client's Children – there were no children age 3 or older in the household during the reporting period.

2. Use the Confidence Assessment Column to indicate the degree to which you are confident in your scoring for each domain. Provide a confidence score of 1 through 5 based on the following scale: ***1. Not At All Confident, 2. Very little confidence, 3. Moderately Confident, 4. Very Confident, and 5. Extremely Confident.***

Domain	1 In Crisis	2 Vulnerable	3 Safe	4 Building Capacity	5 Empowered	Outcome Status	Confidence Assessment
Housing	Homeless or threatened with eviction.	In transitional, temporary, or substandard housing; and/or current rent/mortgage is unaffordable (over 30% of income).	In stable subsidized housing that is only marginally adequate.	In stable subsidized housing that is adequate.	Household is in adequate, unsubsidized housing.		
Employment: Parent 1	No job.	Temporary, part-time, or seasonal job; inadequate pay and no benefits.	Employed full-time; inadequate pay; few or no benefits.	Employed full-time with adequate pay and benefits.	Maintains permanent full-time employment with adequate pay and benefits.		
Employment: Parent 2	No job.	Temporary, part-time, or seasonal job; inadequate pay and no benefits.	Employed full-time; inadequate pay; few or no benefits.	Employed full-time with adequate pay and benefits.	Maintains permanent full-time employment with adequate pay and benefits.		
Income	No income.	Inadequate income and/or spontaneous/ inappropriate spending.	Can meet basic needs with subsidy.	Can meet basic needs without assistance.	Income is sufficient and well-managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps or relies on some other type of assistance.	Can meet basic food needs but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

Directions:

1. Use the Outcome Status Column to indicate your perception of the family's status for each domain. Provide a score of 1 through 5 based on the scale options provided. "Not applicable" is also a response option for the following domains and may only be selected when:

- Employment – the parent is not employable due to disability (unable to work/eligible to receive disability benefits) or age (of retirement age/eligible to receive retirement benefits).
- Childcare – there were no children residing in the household during the entire reporting period (i.e., children were in placement).
- Education of Client's Children – there were no children age 3 or older in the household during the reporting period.

2. Use the Confidence Assessment Column to indicate the degree to which you are confident in your scoring for each domain. Provide a confidence score of 1 through 5 based on the following scale: ***1. Not At All Confident, 2. Very little confidence, 3. Moderately Confident, 4. Very Confident, and 5. Extremely Confident.***

Domain	1 In Crisis	2 Vulnerable	3 Safe	4 Building Capacity	5 Empowered	Outcome Status	Confidence Assessment
Healthcare Coverage	No medical coverage with at least one family member in immediate need of medical care or attention. The family has great difficulty accessing medical care when needed.	Not all family members have medical coverage, with no uncovered family member in immediate need for medical care or attention. The family has great difficulty accessing medical care when needed.	Not all family members have medical coverage, with no uncovered family member in immediate need for medical care or attention. However, the family is able to access medical care when needed.	All family members have medical coverage, but it may strain the budget or is less than adequate.	All family members are covered by affordable, adequate health insurance.		
Adult Education: HS Diploma/ GED/Addtl Schooling: Parent 1	The client does not have a high school diploma/GED and is not enrolled in high school or a GED program.	No HS diploma or GED, but the client is enrolled in high school or a GED program.	Client has HS diploma/GED, but is not seeking additional education/training to benefit employment	Client has HS diploma/GED, and is seeking additional education/training to benefit employment.	Client has completed additional education/training beyond HS diploma/GED and is in a position where he/she is employable.		
Adult Education: HS Diploma/ GED/Addtl Schooling: Parent 2	The client does not have a high school diploma/GED and is not enrolled in high school or a GED program.	No HS diploma or GED, but the client is enrolled in high school or a GED program.	Client has HS diploma/GED, but is not seeking additional education/training to benefit employment	Client has HS diploma/GED, and is seeking additional education/training to benefit employment.	Client has completed additional education/training beyond HS diploma/GED and is in a position where he/she is employable.		
Language/ Literacy: Parent 1	Literacy or language problems are serious, unaddressed barriers to employment or accomplishing basic day-to-day tasks.	Client has serious language or literacy issues but is enrolled in a literacy or language program.	Client has a sufficient command of English to where language or literacy is not a barrier to employment or accomplishing basic day-to-day tasks.	Client has sufficient command of English but is seeking additional education/training to resolve remaining language or literacy problems.	Client has no language or literacy problems.		
Language/ Literacy: Parent 2	Literacy or language problems are serious, unaddressed barriers to employment or accomplishing basic day-to-day tasks.	Client has serious language or literacy issues but is enrolled in a literacy or language program.	Client has a sufficient command of English to where language or literacy is not a barrier to employment or accomplishing basic day-to-day tasks.	Client has sufficient command of English but is seeking additional education/training to resolve remaining language or literacy problems.	Client has no language or literacy problems.		
Mobility	No access to transportation (public or private).	Transportation is available but unreliable, unpredictable, or unaffordable.	Transportation is available and reliable, but inconvenient.	Transportation is readily available and convenient but not preferred; if client owns a car, lacks either a driver's license or insurance.	Transportation is readily available, affordable, and satisfactory; client has driver's license and a car that is adequately insured.		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

Directions:

1. Use the Outcome Status Column to indicate your perception of the family's status for each domain. Provide a score of 1 through 5 based on the scale options provided. "Not applicable" is also a response option for the following domains and may only be selected when:

- Employment – the parent is not employable due to disability (unable to work/eligible to receive disability benefits) or age (of retirement age/eligible to receive retirement benefits).
- Childcare – there were no children residing in the household during the entire reporting period (i.e., children were in placement).
- Education of Client's Children – there were no children age 3 or older in the household during the reporting period.

2. Use the Confidence Assessment Column to indicate the degree to which you are confident in your scoring for each domain. Provide a confidence score of 1 through 5 based on the following scale: ***1. Not At All Confident, 2. Very little confidence, 3. Moderately Confident, 4. Very Confident, and 5. Extremely Confident.***

Domain	1 In Crisis	2 Vulnerable	3 Safe	4 Building Capacity	5 Empowered	Outcome Status	Confidence Assessment
Disabilities & Physical Health: Parent 1	Acute or chronic symptoms currently affecting housing, employment, social interactions, etc.	Sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Asymptomatic; condition is controlled by services or medication.	No identified disability or health concerns.		
Disabilities & Physical Health: Parent 2	Acute or chronic symptoms currently affecting housing, employment, social interactions, etc.	Sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Asymptomatic; condition is controlled by services or medication.	No identified disability or health concerns.		
Disabilities & Physical Health: Child(ren)	Acute or chronic symptoms currently affecting housing, employment, social interactions, etc.	Sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Asymptomatic; condition is controlled by services or medication.	No identified disability or health concerns.		
Mental Health: Parent 1	Danger to self or others; recurring suicidal ideation; experiencing severe difficulties in day-to-day life due to psychological issues.	Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent issues with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health issues.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems and concerns.		
Mental Health: Parent 2	Danger to self or others; recurring suicidal ideation; experiencing severe difficulties in day-to-day life due to psychological issues.	Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent issues with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health issues.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems and concerns.		
Mental Health: Child(ren)	Danger to self or others; recurring suicidal ideation; experiencing severe difficulties in day-to-day life due to psychological issues.	Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent issues with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health issues.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems and concerns.		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

Directions:

1. Use the Outcome Status Column to indicate your perception of the family's status for each domain. Provide a score of 1 through 5 based on the scale options provided. "Not applicable" is also a response option for the following domains and may only be selected when:

- Employment – the parent is not employable due to disability (unable to work/eligible to receive disability benefits) or age (of retirement age/eligible to receive retirement benefits).
- Childcare – there were no children residing in the household during the entire reporting period (i.e., children were in placement).
- Education of Client's Children – there were no children age 3 or older in the household during the reporting period.

2. Use the Confidence Assessment Column to indicate the degree to which you are confident in your scoring for each domain. Provide a confidence score of 1 through 5 based on the following scale: ***1. Not At All Confident, 2. Very little confidence, 3. Moderately Confident, 4. Very Confident, and 5. Extremely Confident.***

Domain	1 In Crisis	2 Vulnerable	3 Safe	4 Building Capacity	5 Empowered	Outcome Status	Confidence Assessment
Substance Abuse: Parent 1	Meets criteria for severe abuse/ dependence; problems so severe that institutionalized living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Client has used within the last 6 months; evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use (e.g., disruptive behavior, housing problems).	Client has used during the last 6 months, but no evidence of persistent, or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in the last 6 months.		
Substance Abuse: Parent 2	Meets criteria for severe abuse/ dependence; problems so severe that institutionalized living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Client has used within the last 6 months; evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use (e.g., disruptive behavior, housing problems).	Client has used during the last 6 months, but no evidence of persistent, or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in the last 6 months.		
Substance Abuse: Child(ren)	Meets criteria for severe abuse/ dependence; problems so severe that institutionalized living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Client has used within the last 6 months; evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use (e.g., disruptive behavior, housing problems).	Client has used during the last 6 months, but no evidence of persistent, or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in the last 6 months.		
Legal: Parent 1	Current outstanding tickets or warrants, or currently incarcerated.	Current charges/trial pending or non-compliance with probation/parole.	Fully compliant with probation/ parole terms with no charges pending.	Has successfully completed probation/parole within the last 12 months; no new charges filed OR no active criminal justice involvement in more than 12 months but prior arrests pose problem to current self-sufficiency.	No criminal history OR no active criminal justice involvement in more than 12 months (and prior arrests do not pose a problem to current self-sufficiency).		
Legal: Parent 2	Current outstanding tickets or warrants, or currently incarcerated.	Current charges/trial pending or non-compliance with probation/parole.	Fully compliant with probation/ parole terms with no charges pending.	Has successfully completed probation/parole within the last 12 months; no new charges filed OR no active criminal justice involvement in more than 12 months but prior arrests pose problem to current self-sufficiency.	No criminal history OR no active criminal justice involvement in more than 12 months (and prior arrests do not pose a problem to current self-sufficiency).		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

Directions:

1. Use the Outcome Status Column to indicate your perception of the family's status for each domain. Provide a score of 1 through 5 based on the scale options provided. "Not applicable" is also a response option for the following domains and may only be selected when:

- Employment – the parent is not employable due to disability (unable to work/eligible to receive disability benefits) or age (of retirement age/eligible to receive retirement benefits).
- Childcare – there were no children residing in the household during the entire reporting period (i.e., children were in placement).
- Education of Client's Children – there were no children age 3 or older in the household during the reporting period.

2. Use the Confidence Assessment Column to indicate the degree to which you are confident in your scoring for each domain. Provide a confidence score of 1 through 5 based on the following scale: ***1. Not At All Confident, 2. Very little confidence, 3. Moderately Confident, 4. Very Confident, and 5. Extremely Confident.***

Domain	1 In Crisis	2 Vulnerable	3 Safe	4 Building Capacity	5 Empowered	Outcome Status	Confidence Assessment
Legal: Child(ren)	Current outstanding tickets or warrants, or currently incarcerated.	Current charges/trial pending or non-compliance with probation/parole.	Fully compliant with probation/ parole terms with no charges pending.	Has successfully completed probation/parole within the last 12 months; no new charges filed OR no active criminal justice involvement in more than 12 months but prior arrests pose problem to current self-sufficiency.	No criminal history OR no active criminal justice involvement in more than 12 months (and prior arrests do not pose a problem to current self-sufficiency).		
Safety	Environment is not safe; immediate level of lethality is extremely high; possible CPS or police involvement.	Safety is threatened; temporary protection may be available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe but future safety is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Credit	History of bankruptcies, foreclosures, evictions, or repossessions.	Outstanding judgments or garnishments.	Has an unmanageable debt ratio and poor credit, OR has no credit history.	Has an unmanageable debt ratio or poor credit.	Has a manageable debt ratio and good credit.		
Life Skills: Parent 1	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and dependents.		
Life Skills: Parent 2	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and dependents.		
Community Involvement: Parent 1	Not applicable due to crisis situation; in "survival" mode.	Socially isolated, lacks social skills, or unmotivated/does not desire to become involved.	Has adequate social skills and motivation/ desire but lacks the opportunity or knowledge of ways to become involved.	Some community involvement (advisory group, support group, church, volunteering, etc.), but has barriers (transportation, childcare issues, etc.).	Actively involved in community.		
Community Involvement: Parent 2	Not applicable due to crisis situation; in "survival" mode.	Socially isolated, lacks social skills, or unmotivated/does not desire to become involved.	Has adequate social skills and motivation/ desire but lacks the opportunity or knowledge of ways to become involved.	Some community involvement (advisory group, support group, church, volunteering, etc.), but has barriers (transportation, childcare issues, etc.).	Actively involved in community.		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

Directions:

1. Use the Outcome Status Column to indicate your perception of the family's status for each domain. Provide a score of 1 through 5 based on the scale options provided. "Not applicable" is also a response option for the following domains and may only be selected when:

- Employment – the parent is not employable due to disability (unable to work/eligible to receive disability benefits) or age (of retirement age/eligible to receive retirement benefits).
- Childcare – there were no children residing in the household during the entire reporting period (i.e., children were in placement).
- Education of Client's Children – there were no children age 3 or older in the household during the reporting period.

2. Use the Confidence Assessment Column to indicate the degree to which you are confident in your scoring for each domain. Provide a confidence score of 1 through 5 based on the following scale: ***1. Not At All Confident, 2. Very little confidence, 3. Moderately Confident, 4. Very Confident, and 5. Extremely Confident.***

Domain	1 In Crisis	2 Vulnerable	3 Safe	4 Building Capacity	5 Empowered	Outcome Status	Confidence Assessment
Network Support	Extended family or friends uninvolved, uninterested, or unmotivated to provide support.	Extended family/friends lack the ability or resources to help (either financially, emotionally, or materially) or provide negative support.	Client receives some positive support (financial/ emotional/material) from extended family or friends.	Strong support from extended family or friends.	Has healthy and expanding support network.		
Parent-Child Relations	There are safety concerns regarding parenting skills; abuse or neglect is present, or all relations have been severed.	Parenting skills are minimal; client and children do not relate well with one another; potential for abuse or neglect.	Parenting skills are apparent but not adequate; client and children acknowledge and seek to change negative behaviors; are learning to communicate and support.	Parenting skills are adequate; client and children support each other's efforts.	Parenting skills are well-developed; parent-child relationship(s) is stable and communication is consistently open.		
Childcare	Needs childcare but none is available or accessible (including family members).	Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available (including family members).	Affordable, subsidized childcare is available but limited (if family: availability or interest is limited).	Reliable, affordable childcare is available; no need for subsidies (could be a family member).	Able to select quality childcare of choice (could be from among family members).		
Education of Client's Child(ren)	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school but not attending or only occasionally attending classes or whose educational needs are not being met.	One or more children are enrolled in school and attending classes most of the time or who are struggling in at least 3, but not all, of their classes.	All school-aged children enrolled in school and attending classes on a regular basis but are struggling in one or two classes.	All school-aged children enrolled, attending classes on a regular basis, and performing well in school.		
Access to Servicces	Service doesn't exist in a location the person can access or barriers prevent access (e.g. cost of service, transportation, geography, physical or mental disabilities, language, religion, culture, etc.) Is unaware of resources or services that he/she may need or needs help to identify his/her needs. Is unaware of resources or services that he/she may need or needs help to identify his/her needs. Is unable to articulate needs.	Knows his/her needs and where to get services but significant barriers inhibit him/her from accessing services on his/her own. Assistance required. Knows some of his/her needs and where to get services to meet some needs but barriers inhibit him/her from accessing services on his/her own. Assistance required.	Knows what s/he needs; knows how to learn about the services available to meet his/her need; but, has only one option for service provision. Knows what s/he needs, knows how to learn about the services available to meet his/her need; but, has a limited number of barriers that discourage access to services or service alternatives.	Receiving needed services but access barriers may limit choice of providers, geography, times of service or other quality related aspects. Knows what s/he needs; knows how to learn about the services available to meet his/her need; but, choices are limited.	No longer in crisis, no longer needs services or is receiving a full range of services to meet needs. Receiving a full range of services that s/he wants and needs. No significant barriers limit access to needed services.		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

OPTIONAL: Final Score Sheet – For Data Entry

DOMAIN	OUTCOME STATUS	CONFIDENCE ASSESSMENT
Housing		
Employment: Parent 1		
Employment: Parent 2		
Income		
Food		
Healthcare Coverage		
Adult Education: HS Diploma/GED/Addtl Schooling: Parent 1		
Adult Education: HS Diploma/GED/Addtl Schooling: Parent 2		
Language/Literacy: Parent 1		
Language/Literacy: Parent 2		
Mobility		
Disabilities and Physical Health: Parent 1		
Disabilities and Physical Health: Parent 2		
Disabilities and Physical Health: Child(ren)		
Mental Health: Parent 1		
Mental Health: Parent 2		
Mental Health: Child(ren)		
Substance Abuse: Parent 1		
Substance Abuse: Parent 2		
Substance Abuse: Child(ren)		

KFT Quarterly Report – Paper Version of Intermediate Outcomes Survey

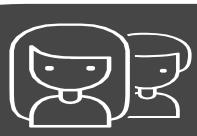
DOMAIN	OUTCOME STATUS	CONFIDENCE ASSESSMENT
Legal: Parent 1		
Legal: Parent 2		
Legal: Child(ren)		
Safety		
Credit		
Life Skills: Parent 1		
Life Skills: Parent 2		
Community Involvement: Parent 1		
Community Involvement: Parent 2		
Network Support		
Parent-Child Relations		
Childcare		
Education of Client's Child(ren)		
Access to Services		

Keeping Families Together

Data Tips

CONNECT WITH OOH FOR HELP WITH ALL DATA QUESTIONS

- Please email the Office of Housing team at **DCF.OfficeofHousing@dcf.nj.gov** with data questions.
- As a reminder, **NEVER** include identifying information in the body of an e-mail.



Enlist a 2-person verification process

Completeness and accuracy in reporting is crucial in evaluation. Please assign two people to review the reports for quality concerns prior tosubmission.

NJS SPIRIT IDs

Please be sure you are entering the correct NJS SPIRIT IDs. The Case ID and Person ID **MUST** be different. Connect with the OOH team or DCP&P worker if help is needed regarding either ID number.

DOUBLE CHECK DATES

Dates can be a common source of data entry error. The most common data issue we observe involve thefamily's enrollment date. Below we've included a few reminders about enrollment and subsequent dates.

- **Enrollment**: The enrollment date in reporting refers to the date that provider staff meets the family to discuss the program AND the family agrees to participate. *It is usually the same as the Intake Date.*
- **Baseline Survey (Survey Monkey)**: A baseline survey for the family should be entered into Survey Monkey within 30 days ofthe enrollment date.
- **Intermediate Outcome Survey (Quarterly Report):** When a family first enrolls in the program, an intermediate outcomes survey should be completed with the family within 30 days of the enrollment date. The survey will then be entered into the Quarterly Report for the quarter in which thefamily enrolled. For example, if a family enrolls on 7/12/22. The outcomes survey should be completed with the family on or before 8/12/22. The outcomes survey would then be entered into the quarterly report for Q1 (July-Sept).

QUARTERLY REPORTS

- **Services Survey:** The services survey in the quarterly report should be completed for ALL families that were actively enrolled in KFT during the reporting period. If they did not receive services, answer "No" to the service questions in the survey.

- **Intermediate Outcomes Survey**:
  - *The first survey* should be completed in the quarter that the family enrolled.
  - *Intermediate Outcomes* should be completed for all KFT families and reported in Q1 and Q3 ONLY.