Instructions for Child Welfare Services Provider Program Evaluation

(1) As Stated in the proposal.

(2-3) Self explanatory.

Complete #4, #5, and/or #6 as applicable to service and as stated in the Proposal.

(4) "Total Clients Served" is defined as the number of different adults and children served directly (e.g. face-to-face service contact) by the program. **

(5) "Total Children Served" is defined as the number of different children served directly (e.g. face-to-face service contact) by the program.**

For Family-Centered Programs (e.g. Home-Based Caseworkers, Homemakers, Home-Based Therapist): "Total Children Served" is defined as the total number of children in the families served who benefited from the service (regardless of whether child (ren) were directly served).**

For Sexual Abuse Treatment and Counseling Services: "Total Children Served" is defined as the number of different children served directly (e.g. face-to-face service contact) by the program. **

(6) "Total Families Served" is defined as the primary caretaker(s) with their children. Count foster parents as separate family units only when the goal was to avoid foster family disruption or for permanency planning. For sexual abuse programs, if the perpetrator is being served and is a parent, guardian, custodian, or relative (e.g. live-in boyfriend, father, step-father, grandfather, uncle) - whether in or out of the home it is considered one family unit: if the perpetrator is a non-familial (e.g. baby-sitter, neighbor, stranger), it is considered separate family units.**

(7) "Race of family" identified by the race of the family/client that was referred (Total in #8 should equal the number of families in #7). If more than one racial group is represented in the family, the family shall be considered bi-racial.

(8) As stated in the contract.

(9) As stated in the contract.

(10) Number of units provided and billed for the evaluation period

(11) Actual unit cost of this service as per the provider internal cost accounting procedures. Attach documentation.

(12) The dollar amount the actual unit cost was above or below the contracted unit rate.

(13) Average length of service for discharged CL/CH/FA, circle one, regardless of funding year.

(14) Average # of units of service for discharged CL/CH/FA, circle one, regardless of funding year.

(15) The total of all claims billed to this program.

(16) Total Cost of Services provided divided by the total CL/CH/FA (circle one) served (#4, 5 or 6)

(17-20) Self explanatory. Enter the start date of the program as stated in the contract.

(21) Only count a family as discharged when everyone in that family unit that was being served has been discharged. (Total in #19 should equal 21a through 21m)

(22) "Families Completing Planned Service" should be equal to 23a. Calculated as follows: Total Cost Billed per Family Completing Service (from first date of service to date of discharge) ÷ Total Number of Families Completing Service.

(23) "Families Not Completing Planned Service" should be equal to 23b through 23f. Calculated as follows: Total Cost Billed per Family Not Completing Service (from first date of service to date of discharge) ÷ Total Number of Families Not Completing Service.

(24-28) Service Tracking Units

* If you define "Client", "children" or "family" differently than stated here, state the definition in a footnote on the Summary Sheet.

CHILD WELFARE SERVICES PROVIDER PROGRAM EVALUATION FOR _____REGION
EVALUATION PERIOD: 07/01/0_____ TO 06/30/0_____

(1) TITLE OR PROGRAM: _____
(2) SERVICE PROVIDER: _____
(3) COUNTIES SERVED: _____

TOTAL **(4)** CLIENTS SERVED: _____ **(7)** RACE OF CLIENT/CHILD/FAMILY (# in each Category)
(5) CHILDREN:_____ WHITE BLACK HISPANIC NATIVE AMER. BI- RACIAL
(6) FAMILIES:_____ _____ _____ _____ _____ _____

(8) Service Unit	**(9)** Unit Billing Rate	**(10)** Number of Units Provided	**(11)** Actual Provider Cost/Unit	**(12)** Unit Cost Over or Under Proposal	**(13)** Average length of service discharged Client/Child/Family	**(14)** Average # Service units Discharged Client/Child/Family
A.						
B.						
C.						
D.						
E.						

(15) TOTAL TITLE IV-B COST of the Program for Services Provided			**(16)** Average Cost for Services Provided by:	
IV-B PART I/SSBG			Client	
IV-B PART II			Families	
COUNTY FUNDING			Children	

(17) # FAMILIES In Program	
(18) # NEW FAMILIES Admitted Since	
(19) # FAMILIES Discharged	
(20) # FAMILIES in Program	

(21) DISCHARGE BY REASON (Refer to number in # 19):	Number of Families
a. Completing planned service	
b. Parents(s) incarcerated	
c. Client refused to initiate services	
d. Client withdrew from services	
e. DCS withdrew family	
f. Agency withdrew family	
g. Client referred to another service (same agency)	
h. Client referred to another agency	
i. Client moved from service area	
j. Client incarcerated	
k. Client moved to another funding source	
l. Parental rights terminated	
m. Other (explain)	

(22) ***TOTAL*** average cost per family completing the planned service (refer to discharge reason "a.")
Include costs from all applicable funding years: $_____

(23) ***TOTAL*** average cost per family ***NOT*** completing the planned service.
Include costs from all applicable funding years: $_____

The following service standards Adoption-Child Preparation, Adoption-Family Preparation, Adoption Pre/Post Placement and Post Adoption Services, Adoption Step-Parent Adoption and Custody Studies, Assessment-Parenting/Family Functioning, Chafee IL, Counseling-Individual/Family, Diagnostic and Evaluation Services, Home Based Family Centered Casework, Homemaker/Parent Aid, Parent Education, Therapy-Functional Family Therapy, Home based Family Centered Therapy and Visitation Facilitation-Parent/Child Sibling billable units are now using an inclusive rate. As part of your annual evaluation you will still be expected to collect monthly time spent for the following:

(24) Child and Family Team Meeting.
Includes Child and Family Team Meeting initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

(25) Court Time on case:
Services include providing any requested testimony and/or court appearances including hearings or appeals. Includes up to one hour for preparation of a DCS requested and approved court testimony. The provider may bill up to one hour per day for testimony in client/family specific court hearings as requested and approved by the DCS.

(26) Travel Time:
1) Travel Time with the client is factored door to door from the service provider's home or the agency's office, whichever is closest to the client. If both these locations are outside the county being served, travel time is to begin at the county line unless otherwise approved by the referring DCS.
2) Travel time is to include only travel to and from the client/family's home, to and from case conferences, court, other related transportation needs of the family, and no shows. The travel time rate includes mileage expenses at the State rate of .40 per mile. Mileage expenses are not to be billed in addition to travel time.

(27) No Show:
1) Includes attempted scheduled home visits with the identified client/family for which the client/family does not appear. Upon the 3rd consecutive "no show", the provider must contact the referring FCM to determine if continuation of services is appropriate.
2) Includes attempted unscheduled home visits if such visits are requested by the DCS via the Referral Form, the DCS Case Plan, or subsequent DCS Progress or Case Notes.
3) Wait time for a "No Show" must be no less than 15 minutes. A note must be left to inform the client/family that a contact attempt was made.
"No Shows" are to be billed per occurrence.

(28) Collateral contacts:
Means obtaining information concerning a child, parent, or other person responsible for the child from a person who has knowledge of the family situation but was not directly involved in referring the child or family to the Department for services.

MONTHLY HOURS SPENT
24-28

	COURT TIME ON CASE	CHILD AND FAMILY TEAM MEETING	COLLATERAL CONTACTS	TRAVEL TIME	NO SHOW	
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
Total						

COMPLETED BY: Name _____ Position _____

Telephone Number: _____ Date: _____

CFCIP SERVICES ANNUAL EVALUATION REPORT FOR REGION

EVALUATION PERIOD: _____/ _____/_____ To _____/ _____/_____

SERVICES OUTCOMES

List below the outcome objectives of the program as stated on the program summary sheet. Include both the proposed outcomes and the achieved outcomes using the measurement criteria included in the proposed outcomes.

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

CFCIP SERVICES ANNUAL EVALUATION REPORT FOR REGION

EVALUATION PERIOD: _____/ _____/_____ TO _____/ _____/_____

EVALUATION NARRATIVE

A. Briefly describe, on pages to be attached, the program as it was delivered. Include any changes or modifications made since the original proposal, as well as the purpose of all changes.

B. If for any objective, the outcome percentages or numbers are below those stated in the program summary sheet, state why this has occurred and suggest changes that might improve the program's future success.

C. If for any objective, the outcome percentages or numbers meet or exceed those stated in the program summary sheet; comment briefly on the elements of the program that have proved to be particularly helpful.

D. Identify/discuss achievements that were realized as a result of the program that were not included as part of the original proposal.

CFCIP YEAR END PROGRAM REPORT

Region: _____

Title of Project: _____

Provider Name: _____

Counties Served: _____

_____

Date Submitted: _____

Attach the following to this face sheet:

_____ **Year-end Program Report Form**

_____ **660 Form**

_____ **Individual narrative**

_____ **Client Tally Sheet**

_____ **Recommendations for program modifications**

_____ **Room and Board Report**

Provider: Submit Face Sheet and Attachments to Regional Coordinator at:

_____
_____
_____
_____

Coordinator: After examining reports for completeness and accuracy, attach Narrative Evaluation of Regional IV-E IL Program(s) and submit to:

MS-47, ATTN: Programs and Services
Department of Child Services
302 West Washington Street, Room E306
Indianapolis, IN 46204-27723

To be submitted no later than July 31st

Region: _____
(for period July 1st to June 30th)

Project Title: _____

Provider Name: _____

CLIENT TALLY SHEET

Description of CFCIP Eligible Population Served by Provider

1. _____ Total youth served

1. **_____ Number of youth who received CFCIP services, but withdrew before completing entire program**

2. Age

_____ 14 years
_____ 15 years
_____ 16 years
_____ 17 years
_____ 18 years
_____ 19 years
_____ 20 years to 20 y, 11 mo, 29 day
_____ TOTAL (must agree with # 1)

3. Gender

_____ Male
_____ Female
_____ TOTAL (must agree with # 1)

4. Race

_____ White
_____ Hispanic
_____ Black
_____ Asian or Pacific Islander
_____ Native American or Native Alaskan
_____ Bi-racial
_____ Missing data
_____ TOTAL (must agree with # 1)

5. Living arrangement of Youth

_____ Licensed Foster Home
_____ Group Home
_____ Living Independently
_____ Correctional/Child Caring Institution
_____ Legal Guardian's Home
_____ Relative Home
_____ Own Home/reunified with parents
_____ Other
_____ TOTAL (must agree with # 1)

6. _____ Special Needs (unduplicated)
Community Service

Special Needs defined as:
-Emotional Disturbance
-Developmentally Disabled
-Diagnosed Specific Learning Disability
-Hearing, Speech, or Sight Impairment
-Other Physical Handicap
-Medical Condition-Clinically Diagnosed

-Race
-Sibling Group (needing IL services does not qualify as a special need)