House District 27, 42

Senate District 13, 20

THE TWENTY-SIXTH LEGISLATURE
HAWAII STATE LEGISLATURE
APPLICATION FOR GRANTS & SUBSIDIES
CHAPTER 42F, HAWAII REVISED STATUTES

Log No: 14-0

For Legislature's Use Only

Type of Grant or Subsidy Request:

☒ GRANT REQUEST – OPERATING ☐ GRANT REQUEST – CAPITAL ☐ SUBSIDY REQUEST

"Grant" means an award of state funds by the legislature, by an appropriation to a specified recipient, to support the activities of the recipient and permit the community to benefit from those activities.

"Subsidy" means an award of state funds by the legislature, by an appropriation to a recipient specified in the appropriation, to reduce the costs incurred by the organization or individual in providing a service available to some or all members of the public.

"Recipient" means any organization or person receiving a grant or subsidy.

STATE DEPARTMENT OR AGENCY RELATED TO THIS REQUEST (LEAVE BLANK IF UNKNOWN):
HUMAN SERVICES

STATE PROGRAM I.D. NO. (LEAVE BLANK IF UNKNOWN): _____

1. APPLICANT INFORMATION:

Legal Name of Requesting Organization or Individual:
Child and Family Service
Dba:
Child and Family Service
Street Address:
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2. CONTACT PERSON FOR MATTERS INVOLVING THIS APPLICATION:

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3. TYPE OF BUSINESS ENTITY:

☒ NON PROFIT CORPORATION
☐ FOR PROFIT CORPORATION
☐ LIMITED LIABILITY COMPANY
☐ SOLE PROPRIETORSHIP/INDIVIDUAL

6. DESCRIPTIVE TITLE OF APPLICANT'S REQUEST:

FUNDING FOR CRITICAL SERVICES FOR PERMANENCY SUPPORT SERVICES ON THE ISLAND OF OAHU

4. FEDERAL TAX ID #: [redacted]

5. STATE TAX ID #: [redacted]

7. AMOUNT OF STATE FUNDS REQUESTED:

FY 2012-2013: $160,389.00

8. STATUS OF SERVICE DESCRIBED IN THIS REQUEST:

☐ NEW SERVICE (PRESENTLY DOES NOT EXIST)
☒ EXISTING SERVICE (PRESENTLY IN OPERATION)

SPECIFY THE AMOUNT BY SOURCES OF FUNDS AVAILABLE AT THE TIME OF THIS REQUEST:

STATE $ 0
FEDERAL $ 0
COUNTY $ 0
PRIVATE/OTHER $ 0

T[redacted]

HOWARD S. GARVAL, PRESIDENT AND CEO
NAME & TITLE

1/31/12
DATE SIGNED

Application for Grants and Subsidies

I. BACKGROUND AND SUMMARY

In November 2011, the Post Permanency Services program was eliminated from the Department of Human Services' budget. The program provided support to adoptive parents and children in order to prevent disruption of the newly formed family unit. The services help to prevent multiple placements of children which can be very traumatic.

Often, both children and parents are overwhelmed with the special needs that accompany children who have been removed from their birth family due to abuse and/or neglect. The purpose of Post Permanency Services is to prevent the disruptions of the newly formed family unit by providing custom-tailored support, intervention and education. The support offered by this program is designed to walk alongside the family providing knowledge about adoption and permanency issues that many other services do not specialize in.

Without services, the adoptive family unit will be left alone to manage issues that arise. This in turn increases the probability of placement disruption. This will result in the child going back into the foster care system. In addition, many children in the program have mental health disorders and will not be able to function in another home setting. If a disruption in placement occurs, many will end up in the mental health system. This will result in the cost of care for these children transferring from the Department of Human Services to the Department of Health.

Child & Family Service is requesting $160,389.00 to restore Post Permanency Services to these vulnerable families and children.

1. A brief description of the applicant's background

Child & Family Service (CFS) is a private nonprofit organization that has been serving Hawaii's families continuously since 1899 – more than *a century of caring*. We maintain a comprehensive integrated delivery system that encompasses a wide array of services provided to populations ranging from infants to elder adults, throughout the State, on the islands of Oahu, Hawaii, Kauai, Maui, Molokai, and Lanai. CFS has 37 programs, more than 400 employees and 100 volunteers that deliver services to fulfill our mission of **"Strengthening families and fostering the healthy development of children"**.

The broad spectrum of services provided by CFS include: domestic violence intervention and transition services, case management, foster and therapeutic foster care; adoption services; residential group homes, alternative education for alienated youth, prevention and treatment of child abuse, and family, school, and community-based counseling services for children and their families. Infants, children, adolescents, young adults, older adults, individuals, and families in need benefit from these services.

CFS's programs are responsive, flexible, and focused on positive outcomes. Services are provided in homes, schools and in the community as well as 35 CFS offices and service

sites throughout the State. CFS's strength lie not only in its size and ability to share expertise and resources statewide, but also in its ability to adapt services so that they are unique and appropriate to the island and communities it serves.

The overall goals of CFS are to:

1. Improve an individual's functional and clinical status (emotional, psychological well-being, development and independent living skills);
2. Improve an individual or family system's ability to cope with stressors in their lives; and
3. Improve the health, welfare, and safety of individuals so that they are safe from harm, abuse or neglect.

CFS has had numerous contracts over the past two decades with the Department of Human Services (DHS) to provide a comprehensive array of services for critical populations which include foster care and therapeutic foster care for children in Hawaii. CFS is already a CPO, a Certified Placing Organization, licensed by the DHS to provide foster care. CFS has provided adoption services in Hawaii since 1935. CFS also has a number of contracts to provide services for the State of Hawaii Department of Health, Child and Adolescent Mental Health Division. Previous and current outcomes demonstrate CFS's ability to assist families and children with special needs

CFS created and implemented a program to assist the placement of difficult-to-place children from foster care into permanent loving homes called Permanency Support Services (PSS). CFS has been successfully providing PSS to families on Oahu since 1999. The PSS Program demonstrated a 94% success rate in preventing disruption to the child's placement with a family. CFS has been able to provide services that are critical to achieving permanent, stable, and nurturing families for children, as well as maintaining those families who have already adopted or assumed legal guardianship on the island of Oahu.

The Council on Accreditation (COA) has accredited CFS since 1980. As a member of COA, CFS maintains the highest standards in organization management and program delivery. CFS has also been a member of the Alliance for Children and Families since 1986. Because of its accreditation status and membership in national organizations, CFS has access to current research data and best practice models.

2. *The goals and objectives related to the request*

The goals of the Permanency Support Services program are:

1) To support adoptive families by providing support services as necessary so they can make a lifetime commitment to their children.
2) To increase and to maintain the number of adoptive families.
3) To prevent disruption of the family unit.
4) To reduce the recurrence of child abuse and/or neglect in foster care.

5) To reduce time in foster care to adoption.
6) To increase placement stability.
7) To reduce placements of young children in group homes or institutions.

These goals reflect the three broad outcome domains in the continuum of child welfare services: safety, permanency, and child and family well-being.

The objectives of the program are:

1) 95% of families will have no confirmed reports of child maltreatment during program services.
2) 95% of families will have no placement disruptions during program services.
3) 80% of families receiving intensive in-home services will demonstrate progress towards their treatment goals.
4) 80% of children will demonstrate improvement in the attainment of their developmental milestones.
5) 100% of adoptive parents, legal guardians, and/or permanent custodians seeking information and/or referrals to permanency resources will receive assistance.
6) 80% of adoptive parents, legal guardians, and/or permanent custodians will report satisfaction with seminars, workshops, and trainings.
7) 80% of service providers will report satisfaction with seminars, workshops, and trainings.

3. *State the public purpose and need to be served*

Families who adopt and provide guardianship for children, and those families who are considering adoption or guardianship face unique challenges and needs. The adopted child comes with a myriad of issues and concerns that require a high level of commitment and understanding, as well as specialized knowledge and skills from those who care for them. Parenting the adopted child differs in many ways from parenting a child who was born into the family unit. For an adopted child, issues of separation and abandonment can be life-long challenges that manifest during different developmental stages. It is critical that adoptive parents recognize the impact that a child's experience of separation from his/her birth parents has on him/her, even if the child has no memory of those parents. Adopted children experience many losses, including the loss of their birth family, the loss of their identity and a loss of self-worth. These children, along with their adoptive families, must learn to come to terms with this grief and develop appropriate ways of identifying and expressing their feelings.

Many adoptive parents face their own unresolved issues, including issues relating to their childhood and relationships with their own parents, and in some cases, challenges surrounding their own infertility. These parents not only need assistance in learning to deal with their past challenges, but they also require assistance in learning to accept and appreciate their adopted child's own roots and genetic makeup. Some adoptive parents may need help in learning to let go of their unrealistic expectations about adoption and

their adopted child and focus instead on dealing with the realities of their children and their family.

The issues of grief and loss are at the very core of working with adoptive families. Additionally, a plethora of other treatment issues can and often do arise, and as a result, specialized education and training becomes of the utmost importance. While not exclusive to the adoptive child, there are several issues that have a higher prevalence in children who were adopted than the general population. Children who were placed in foster care have also been found to be at a disadvantage. According to the Child Welfare league of America more than half the children in foster care have some type of mental health disorder. Foster care has been proven in innumerable studies to not be conducive to academic performance. In a study conducted in Philadelphia by John Hopkins University, high school students had a 75% probability of dropping out of school if they were in foster care, had been abused and neglected, or ordered into an out-of-home placement by the courts.

Children adopted from the foster care system often face a daunting variety of physical and emotional special needs, such as attachment disorders, oppositional defiant disorder, depression and anxiety, mental illness, sexual abuse, fetal alcohol syndrome or effect, attention deficit hyperactivity disorder, central auditory processing disorder, emotional disabilities, learning disabilities, mental retardation, orthopedic impairments, speech and language impairments, serious medical conditions such as HIV/AIDS and other severe physical disabilities.

One almost "universal" condition seen in the treatment of adoptive families is some form of attachment disorder. Other common issues that adopted children bring with them to the new family are: Sexual Abuse; Attention Deficit (Hyperactivity) Disorder and other Impulse Control Disorders; Learning Disabilities; Low Self-Esteem; Anxiety; Depression; and Unresolved Grief and Loss. Families are often not equipped to cope with the special needs of these children. They don't understand why love isn't enough to "make the behavior go away." CFS staff are well prepared to assist families with the challenging conditions and behaviors often present in permanency situations. The CFS staff will assist adoptive families by educating them on the different disorders to help them have a better understanding on how they can assist the client more effectively.

Child & Family Service (CFS) proposes to offer Permanency Support Services to approximately 50 families on Oahu each program year. Families are referred by the Department of Human Services Child Welfare Services Branch (DHS-CWS), other professional agencies, or self-referred and are composed of adoptive, legal guardianship, or permanent custodial families. "Adoptive" refers to families who adopted through the Department of Human Services, through Interstate Compact (ICPC) or internationally. Those families with children who are, or who have been, involved in Child Welfare Services receive the highest service priority.

The program strives to enhance the well-being of children and families in a safe and stable home environment. Pre and post permanency support is critical to achieving the

goal of finding permanent, stable, loving families for children, as well as maintaining those families who have already adopted. Parents need information that will strengthen their families and enable them to handle the challenges of adoptive parenting. CFS' PSS Program understands that adoption is a lifelong process. It is clear that the need for ongoing mental health support and services does not end when permanency is legalized.

A review of recent research and literature shows that developmental challenges that emerge prior to and during the foster care experience are bound to have an impact on a child's relationships prior to, during, and throughout the adoption experience. These challenges have lifelong implications for the entire family. As a result, pre and post-adoption services are essential to helping children and families develop secure attachments and build healthy relationships.

By working in collaboration with the family, social service agencies, and mental health resources, PSS has provided:

- A foundation for the child's continued development.
- An environment for change.
- A commitment to the family unit.
- A healthy framework within which the family can stabilize and grow.

4. *Describe the target population to be served*

The target population includes the following:

1) Pre-permanency (adoptive, legal guardianship or permanent custodial) families that are referred by CWS, another professional agency, or self-referred.
2) Families that have adopted, assumed legal guardianship, or assumed permanent custody of a child and are referred by CWS, another professional agency, or self-referred.
3) Families referred by Child Welfare Services will have first priority when there are more referrals than can be served with available resources.

5. *Describe the geographic coverage*

Services will be rendered on the island of Oahu.

II. SERVICE SUMMARY AND OUTCOMES

1. *Describe the scope of work, tasks and responsibilities*

The PSS is a free and voluntary program designed to preserve the placement of adoptive children and children who are in long-term, permanent placement with a new family. CFS has been successfully providing Permanency Support Services to families on Oahu since 1999. This is accomplished by providing custom-tailored support, intervention and

education. Staff meets the family in their own home at times most convenient to the family.

The PSS staff have a wide range of activities and responsibilities. They will assess the family's skill building, child development, and behavior management current capabilities and needs. PSS teaches the families the skill sets they need to achieve their goals. PSS staff assist the family in developing personal support networks and in participating in ongoing services as needed. PSS provides support and linkage to government and community resources. The service activities address the unique physical, social, emotional, cultural, and educational needs of each child and family and increase the family's ability to protect the child.

CFS provides these services in concurrence with the philosophy and treatment goals related to the paramount safety of children and the family's ability to be protective of the child.

The PSS staff utilizes up to date research and information on best practices and also draws upon its experience working with permanency families to determine the most effective treatments and service delivery methods. The program has found that utilizing psycho-educational and cognitive behavioral modalities are effective at helping adopted children and their families deal with many of their challenges.

PSS has found Filial Therapy (where a parent is taught how to conduct non-directive play therapy sessions at home) to be quite effective in increasing the parent-child bond and promoting healing within the child and the family. Families are also taught "*Positive Parenting*" skills to increase their effectiveness in supporting their child.

Positive Parenting is a video-based parent education curriculum which includes reading materials, homework assignments and exercises designed to educate the entire family in effective familial relationships. There are two age-specific curricula: Parenting of Young Children and Parenting Teens.

The following are the five key areas of program service delivery for the PSS Program:

1) Referral and Intake
2) Assessment and Service Planning
3) Direct Service Provision
4) Coordination with Department of Human Services and other agencies
5) Quality Assurance, Grievance and Dispute Resolution Procedures.

Service Activities include:

1) Information and Referral Service

Referrals primarily come from the Child Welfare Services (CWS), other professional agencies or self referral. Families are eligible for this service when they are caring for

adopted children, have accepted legal guardianship or permanent custody of children, or are fostering children who they are considering adopting. Priority is given to CWS referrals.

When the referral is received, it is reviewed by the Program Administrator. The staff contacts the family or caregiver to share the program information and see if the family would be interested in services. Once the family or caregiver accepts services, the Social Worker/Therapist then meets the family and completes an assessment.

2) Assessment and Service Planning with the Family

The Social Worker/Therapist completes a DHS Safety Assessment as well as the CFS Comprehensive Basic Assessment within 30 days. During the assessment process, the Social Worker/Therapist approaches the family with a non-judgmental demeanor, focusing on strengths and supports that the family possesses.

An Individual Program Plan (IPP) is created with input from the family, family support systems, DHS or any other community providers involved with the family. The IPP focuses on the reason for referral and contains obtainable, measurable and time limited goals/objectives with the primary focus on the child's well-being.

3) Direct Service Provision

Services are delivered in the place most convenient to the family, usually the family home. The time of the service delivery meets the convenience of the family schedule. Evening and weekend hours are available.

The services are designed to meet the individual needs of the family. Services usually occur for no less than three months. The majority of families discontinue services or reduce to an as needed basis between 3 and 6 months. All clients are informed of the 24-hour availability of service through the crisis beeper. Through weekly case conferences all staff are familiar with all client cases. In emergencies staffs have access to all client files.

Ongoing services for each family occur over a period of time, not to exceed 12 months. During this timeframe, the Social Worker/Therapist, CDS, and FSW may see the family daily, weekly or bi-weekly, depending on the family's needs. Ongoing engagement with the family is essential in order to ensure that the IPP goals and objectives are met.

In home crisis intervention services may be provided up to 3 months to prevent an out-of-home placement. Services include counseling, case management, role modeling, mentoring and education. Below are some common challenges that youth and families face in the PSS Program and some of the interventions staff employ.

The work plan gives a clear description of the services provided to the PSS families. In the following section, several of the more common challenges that adoptive families encounter, and the interventions that PSS utilizes, are discussed. Staff receives regular training both internally and externally to keep up to date with treatment and referral information for the families we serve.

The following are a list of disorders frequently encountered by staff and the treatment options offered by the staff in their service delivery:

Mental Illness (Depression and Anxiety)

Concept

Most of the children who are adopted out of foster care each year experienced unresponsive or inconsistent care giving before entering foster care and had many placements while in care. As a result, they often have significant mental health needs, such as depression or anxiety disorders—needs that may not diminish as they grow older.

Research shows that children who experience abuse and neglect (particularly at early ages), those who stay in foster care for an extended time, and those who move multiple times while in care are at particular risk of mental health problems.

Effect on the Family

Permanency families may not be aware of the scope of their child's mental health issues in the early stages of the child's development. Some children may be adopted by a family as a toddler and then begin experiencing severe mental health issues in adolescence. Families may lack the knowledge about how and where to obtain mental health services. Parenting a child with a mental illness can take a significant toll on the health and emotional well-being of the family as a whole, including the child, parents, siblings, and extended family. Families who have adopted a child with mental health issues report needing assistance in many areas, including advocating for services, locating service providers who specialize in the type of counseling needed for their child, learning about the mental health issues, and working with the government and private insurance to pay for the costly services.

Treatment

If a mental health illness has already been identified, PSS staff member can educate families about the symptoms and indicators of the diagnosis, using the DSM –IV. The PSS Program's extensive resource library is also used to provide parents with books and other educational materials. The resource material is reviewed with the family during visits and parents are encouraged to ask questions and learn about specific techniques and tools that may helpful in working with a child with the specified mental health diagnosis.

If a family is concerned that their child may have an undiagnosed or mis-diagnosed mental health illness, then PSS staff members can refer the family to a psychiatrist for

a full psychological evaluation. PSS also provides families with information and support during a crisis situation, including referrals to Kahi Mohala or Queens for inpatient services. The PSS staff work collaboratively with other service providers, including attending treatment team meetings with the family. Once a diagnosis is made, PSS works with the family to provide the necessary education and offers skill building tools.

Sexually Acting Out/Sexual Abuse

Concept

Many children enter the foster care/adoption systems because of issues of sexual abuse and failure of their parents to protect them. Parents caring for the sexually abused child face many difficult issues and are often at a loss as to how to support their child. Sexually acting out may be signs and symptoms of deeper issues.

Effect on the Family

Parents may be ill-equipped or unprepared for some of the acting out behaviors of sexually abused children. Often these children exhibit a strong interest or curiosity in sex and may have advanced sexual knowledge. The child might demonstrate strong sexual themes or sexualized behavior during play and use seductive behaviors with younger peers or siblings. Parents are often appalled and at a loss as to how to deal with these behaviors. Some parents have their own issues of past sexual abuse and feel uncomfortable talking about sexual abuse with their child.

Treatment

With sexual abuse, there are primary and secondary symptoms/issues that need to be addressed. The primary issues are ones of fear and anxiety that emerge as a result of the abuse. These are sometimes diagnosed as post-traumatic stress disorder (PTSD), in which the victim might "relive" the abuse and become avoidant, withdrawn, and/or hypervigilant in order to avoid reabuse.

The secondary symptoms/issues are many: lack of trust, sexualized behavior, poor self-esteem, depression, behavior problems, anger, aggression, withdrawal, and authority issues. Sometimes it is difficult to connect the current symptom(s) to the past sexual abuse and this can delay appropriate treatment.

The CFS PSS staff members will refer the family to a POS sex abuse treatment program for specialized treatment and work with the provider as appropriate to coordinate interventions with the child and the family as a whole. If they are not eligible for these services they will be referred to the Sex Abuse Treatment Center or a private therapist that specializes in sex abuse. PSS staff will also assist by educating the family on how to recognize the primary and secondary symptoms/issues and helping the family become more comfortable in their support of the sexually abused child. By teaching the parents how to communicate with their child and assisting them with their own discomfort, PSS staff assist the family in the

long journey toward healing. PSS works with the family to provide the necessary education and offers skill building tools.

IMPULSE CONTROL DISORDERS

Attention Deficit (Hyperactivity) Disorder

Concept

The incidence of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) is quite high among adopted children. Some theorists believe that these disorders are genetically inherited. Others believe that perinatal substance abuse and/or malnutrition are contributing factors. Attention Deficit Hyperactivity Disorder is characterized primarily by symptoms/behaviors of hyperactivity such as: fidgeting and squirming, difficulty remaining seated, difficulty waiting one's turn, verbal outbursts at inappropriate times, difficulty in remaining on task, jumping from one activity to another, difficulty in playing alone or quietly, excessive talking, interrupting, not listening, and engaging in physically dangerous activities. Attention Deficit Disorder is characterized primarily by symptoms of inattentiveness such as: distractibility, difficulty in remembering or following instructions, difficulty in remaining on task, and losing things. (From DSM-IV-R 1994).

Effect on the Family

Having an ADD/ADHD child in the home or classroom can frustrate and tire the most patient person. The ADHD child is full of never ending energy and has to be monitored every minute. These children are extremely impulsive and can be destructive to their environment and a danger to themselves. The ADD child has a very short attention span and has to be reminded over and over to do even the simplest things. Getting these children to sit still and focus on a task that the adult wants accomplished is often impossible. Yet these children can watch T.V. or play video games for hours at a time and this can confuse parents who can't get the child to sit still long enough to eat or tie his/her shoelaces.

Treatment

Currently the most effective treatment for ADD and ADHD is a three-pronged approach of medication, school support, and behavior management. There are several medications now that are very effective in treating the symptoms of ADD/ADHD. While sometimes controversial, research has demonstrated that the correct medication and dosage can allow a child to be calm enough to learn and be more socially appropriate. The school setting can be modified to work with the child's short attention span and need for constant movement. The parents can be taught effective behavior management techniques that help the child learn to manage his/her condition. Effective limit setting and consistency are crucial in assisting the child in his growth and education.

PSS staff members work closely with parents and schools in order to assist the child in achieving his or her own level of academic excellence. Staff collaborate with parents and school personnel by offering recommendations, attending Individual Education Plan (IEP) meetings, and assisting parents in understanding their child's limitations. By using the Positive Parenting curriculum, PSS staff are able to teach parents and children the skills necessary to deal with the everyday challenges that many of these families face.

Oppositional Defiant Disorder and Conduct Disorder

Concept

Oppositional Defiant Disorder (ODD) is manifested by a pattern of negative, hostile and defiant behavior toward adults. These children act as if anyone in authority is "the enemy." Frequent temper tantrums which include screaming, throwing objects, crying and refusal to follow directions from an adult are often seen. There are frequent displays of anger, resentment, spite and vindictiveness which cause significant impairment in social and academic functioning.

Conduct Disorder is a more severe disorder and often starts out as ODD. It is characterized by the child's persistent failure to comply with the rules and regulations at home, in school or in the community. There is often excessive fighting, intimidation and cruelty toward others which includes violence and destruction of property. For older children and adolescents there can be a history of breaking and entering and stealing. Repeated truancy, suspensions and disrespect toward authority figures at school are common factors. Other challenging behaviors include lying, manipulating and failure to take responsibility for one's actions.

Effect on the Family

Whether a formally diagnosed behavioral disorder or simply a display of difficult behavior, parents are often at a loss and are frustrated in caring for these children. Attempting to gain and retain control of the family environment with a child who consistently refuses to follow even simple directions can often challenge the parent to the point of frustration, helplessness, and anger. Parents with other children might worry about their safety around these aggressive youth. Often, these disorders threaten the stability of the placement. Parents need support and tools to cope with the child and to manage his/her behavior.

Treatment

The PSS team can assist families who are experiencing these and other behavior challenges. Treatment modalities include: teaching parents to understand their child's behavior; modeling effective techniques for behavioral supports; teaching the family games and activities which help to increase the child's self-awareness and self-esteem; family therapy to discuss issues of respect, cooperation and conflict resolution; and support groups and/or supportive counseling for parents to help them overcome their feelings of isolation and frustration. Treatment can also include medication and/or additional intensive individual therapy for the youth. If the family

has not already had their child assessed by a psychologist or psychiatrist, the team might recommend this.

Attachment Disorders

Concept

Attachment Disorder is a condition in which individuals have difficulty forming loving, lasting and intimate relationships. This most often begins with a disruption or absence of the formation of a bond with a parent or other caregiver beginning at a very early age. Many conditions can put a child at high risk for developing an attachment disorder. The critical age is from conception through approximately the first two years of life. These conditions often include a traumatic prenatal experience such as exposure to drugs and alcohol in utero. Parents who neglect or provide inconsistent attention to their infants contribute to, or cause the child to lose the ability to bond or attach to the caregiver. Research has shown that up to 80% of high risk families (abuse and neglect, poverty, substance abuse, domestic violence, history of maltreatment in parents' childhood, depression and other psychological disorders in parents) create severe attachment disorders in their children. Since there are one million substantiated cases of serious abuse and neglect in the U.S. each year, the statistics indicate that there are 800,000 children with severe attachment disorder coming to the attention of the child welfare system each year. This does not include thousands of children with attachment disorder adopted from other countries.

Teen parents or parents who are not willing or able to care for their children are most likely to be in this population. Often, perinatal drug exposure and inattentive parenting go hand-in-hand.

Positive parental/caregiver attention and involvement is critical if a child is to develop normally and learn the basic skills of trust and dependence. The child who has not been cared for in an attentive and affectionate manner will not achieve the normal developmental milestone of trust, but instead learns mistrust and learns to rely only on himself/herself for basic needs. The development of a conscience, cause and effect thinking, ability to delay gratification, and the ability to plan and set goals all rely on the basic formation of trust. Children who do not attach to their caregiver are often relinquished to the foster/adoption system by parents who are not able, or who do not want to care for them.

Effect on the Family

Foster and adoptive parents learn quickly that love and understanding is simply not enough and does not work with the attachment disordered child. There are increased levels of frustration and disappointment and feelings of low self-esteem and incompetence on the part of the parent. After years of unresolved conflict and failed attempts to remedy the problem, most parents feel hopeless, demoralized and burned out. The family often becomes controlled by the child's behavior, often to the point of losing all semblance of a "normal" family life. Often, the attachment disordered child will act out in abusive ways toward other children, siblings and even the family pet.

Typically, joyful family occasions such as Christmas and birthdays become times of increased stressed and unhappy memories. Often parents feel inadequate and even hostile or angry toward the child. Parents' or caregivers' attachment histories play a significant role in their current lives. They must be aware of how prior family-of-origin issues influence their parenting attitudes and practices, marital relationships, and current psychosocial functioning. Parents and caregivers are responsible for creating a framework of love, sensitivity, empathy, caring, security and protection. They must model effective communication, coping and problem-solving skills, and management of emotions for their children

Treatment

The first and largest hurdle in dealing with attachment disorders is to get the entire family involved, including the child. Building basic trust is at the core of building attachment to the family. The first step in treatment is for the family to agree that the child must ask for, and rely on, the parents to provide everything s/he needs. This "mimics" the initial healthy caregiver response where the child was, in reality, truly dependent upon the caregiver to address his/her every need. Balancing love and limits is important for all children, but especially crucial when creating a healing environment for very challenging children. Nurturing and loving care fosters the learning of trust, empathy, and a positive mindset. Providing limits and structure, including rules, clear expectations, and consequences, helps children feel safe, secure, and learn from their mistakes. A sense of order and predictability is particularly important for children who come from chaotic and frightening backgrounds.

The second step in treatment is to require eye contact from the child whenever s/he is communicating his/her needs. The child must recognize there is another human being in his/her environment as well as learning to relinquish control to that individual. Upon achievement of these two very basic steps, attachment can and will develop. Effective parenting with attachment disordered children must provide the same key ingredients as secure parent-infant attachment. Parents provide a balance of structure and nurturance, which changes based on the developmental needs and capabilities of the child. The staff help parents understand that they might have to delay their desire for the child to respond to their affections as a part of the process of helping the child. The parents are taught how to control the great behavioral challenges that the child's behavior may evoke and they are educated on how to cope with the frequency and intensity of inappropriate behavior the child will display.

Learning Disabilities, Speech and Language Impairments and Other Disabilities

Concept

Many children who enter the foster care/adoption systems have delays and challenges in speech, language and learning disabilities interfering and presenting many challenges in their education. It is not uncommon for the youth to be functioning below their potential and in need of support.

Effect on the Family

These delays are often not being addressed by the Department of Education and this leaves families very stressed. The youth may drop out of school or have serious behavioral problems related to school issues. Some schools are not willing to provide support to the families without outside intervention and support.

Treatment

Program staff is able to refer families to parent advocates, attend IEP and school meetings with the families and refer to other interventions services. Examples of programs that can be utilized include Learning Disabilities Association of Hawaii, Hawaii Families as Allies, Easter Seals, Zero to Three, Special Parent Information Network, Exceptional Family Member Program, HILOPA'A Family to Family Health Information Center, Hawaii Coalition for Dads, ASSETS School, Hau'oli Na Keiki Autism School, HeadStart, and Pacific Autism Center.

Work Plan

The following Work Plan details service activities and program requirements, specific tasks, responsible staff and backup staff, and the timeline/schedule.

Child & Family Service
Permanency Support Services Work Plan

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
SERVICE REQUIREMENTS:			
Contract specific policies and procedures for admission and discharge including:	Program policies and procedures for admission through discharge are in place. These include: • Referral and Eligibility • Intake and Admission • Assessment • Service Planning • Discharge • Orientation and Training • Aftercare • Employee Recruiting • Case monitoring and Coordination • Client Assistance • Caseload • CPS Reports • Human Resources • Progress Note Documentation • Program Description • Client Language Preference • Risk Management • Volunteers • Off Site Personnel Safety • Transportation with Private Vehicle • Waiting List • Transporting Confidential Information	Program Administrator	Completed.
1.A. Referral	**Referral**: DHS-CWS determines the criteria for referrals: • Pre-permanency (adoptive, legal guardianship or permanent custodial) • Families that are referred by CWS, another professional agency, or self-referred. • Families that have adopted, assumed legal guardianship, or assumed permanent custody of a child and are referred by	Program Administrator Back up: Social Worker/Therapist or Child Development Specialist (CDS)	Referrals are accepted during regular business hours: M-F, 8:00 a.m – 5:00 p.m. If a referral arrives after hours, it is responded to the next business day.

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	CWS, another professional agency, or self-referred. • Families referred by Child Welfare Services will have first priority when there are more referrals than can be served with available resources. Referrals can occur in a number of ways. Families, CWS workers or other professionals can register or make referrals by telephone, fax, email, or by courier. Referrals are responded to within two business days of receipt. If there is incomplete information on the referral, the PSS staff contact the referring CWS worker to obtain the additional needed information and/or clarification. Program Secretary records the referrals in the database (client eligibility list).		
1.B. Intake & Service Initiation	**Intake & Service Initiation:** When the Program staff receives a referral, they review it and contact the family to arrange for an intake/assessment meeting. When the family is contacted, they are notified that a referral has been made to Permanency Support Services Program. PSS staff explains the goals of the program and describes the free, supportive and short-term nature of the home visiting services. Information discussed and/or assessed with the family during the initial engagement of services includes, but is not limited to: • Reason for referral; • The purpose of the PSS Program; • When and where services are available (flexible to accommodate the family's needs); • Who is able to be involved in the program such as extended family and/or other service providers/supports; • Service timeframes; • Identification of the family's strengths, supports and needs; • Risk factors/protective issues/concerns; • Benefits and risks of services and non-services; • Problem solving ideas and the initial development of a plan of action; and community resources such as The Warm Line, CFS' Permanency Support Line, Access Line and domestic violence hotlines.	Social Worker/ Therapist or CDS Back up: Program Administrator	Attempts are made to contact the family within 48 hours of receipt of referral and arrange a face-to-face visit within one week when possible. PSS staff work evenings and weekends, as needed, in order to meet the needs of the families.

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	When the family accepts services, staff confirm the phone contact and home location information and schedule a face-to-face meeting at a time and place that accommodates the family, usually in the home, in order to complete the intake process. During the first face-to-face visit with the family and/or caregiver, the staff again reviews and answers any questions regarding the PSS Program, as needed to ensure clarity about the goals and objectives of the PSS Program and the reason for referral to PSS. If the family agrees to continue proceeding with services, CFS Notice of Privacy Practices, consent to service, client rights and other intake documents are thoroughly reviewed and signed. Copies of intake documents are provided to the family/caregiver as well. The staff obtain permission to contact and coordinate with any other service providers or community supports involved with the family. The staff then conducts an assessment and begins planning for the Individual Program Plan. The Social Worker/Therapist or CDS also provides, during the first family visit, a list of general parenting and crisis community resources as well as any other resources and educational material that are relevant based on the referral and/or initial contact with the family. If the family refuses services, the staff offer a program brochure and other information as well as an invitation to contact PSS services if the family should later want services. If the referral has come from a CWS worker, the staff contact CWS to apprise them of the family's refusal to participate.		
1.C. Waiting lists or turn-away policies	**Waiting lists and turn-away policies:** When the request for service exceeds program capacity, families referred by the Department of Human Services are given first priority and CWS unit supervisors shall prioritize the cases to be served. Families are notified of any waitlist periods during initial contact by PSS. The waitlist is managed by the Program Administrator and is reviewed and followed-up on during the waiting period. Follow-up contact is made with the families on the waitlist on a monthly basis in order to identify any needed supports.	Program Administrator Back up: Social Worker/ Therapist	Every attempt is made to move a family off the **waiting list** within one week. If the CDS or Social Worker/ Therapist is unable after two weeks to initiate services, the Program Administrator provides

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	Information and referrals to community resources are also be made during these follow-up contacts. **Turn-away policies:** Families are turned away from services if they have no permanency plans or if they decide that they do not want services.		crisis-intervention services to the family as needed. Monthly contact is made with families on the waitlist.
1.D. Discharge criteria & process	**Discharge criteria & process:** Discharge occurs when child/youth and family: a. Achieves their service goals or is otherwise ready to discontinue service - No longer want the organization's service; b. No longer meets eligibility criteria; c. Refuses to meet program standards or requirements or to continue to participate in services; d. Has needs that exceed organizational resources and staff determines that the family needs to be referred back to DHS-CWS; or e. Has exceeded six months of services and an extension of services have not been approved by CWS. f. Drops-out: Cannot be located and has CFS exhausted all means to locate client. Discharge planning begins during the intake process. The Social Worker/Therapist or CDS reviews and provides the families with the client responsibilities during the intake process. The timeframe for services vary according to the needs and goals of the family. During the service period, if the Social Worker/Therapist assesses that the family needs additional assistance and/or the family is requesting additional support past the six month timeframe, the services may be extended with prior approval from CWS. Families can re-access services should they need them after the case is closed. Before the family is discharged, the staff link the family to other community resources, as needed. Upon discharge, the family's progress is reported to the referring CWS worker.	Social Worker/ Therapist Back up: The Program Administrator or Child Development Specialist	Discharge occurs within 6 months from the initiation of services. CWS is notified of case closure within 48 hours. A request for extension is made to CWS as soon as it is anticipated prior to the six month deadline.

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	Discharge Summaries document the child/youth's and family/caregiver's progress during the length of the case. Includes an aftercare plan if needed which identifies the continuum of other services needed or desired by child/youth and family/caregiver, and which specifies the nature and frequency of follow-up or aftercare contact by CFS (if any). These results help the program also evaluate its effectiveness. **Termination of Contract:** Should the term of the CFS contract terminate prior to family's readiness for discontinuation of services, the program will assist in the transition to the new provider.	Social Worker/ Therapist Back up: The Program Administrator Social Worker/ Therapist Back up: Program Administrator	At case closure within 30 days. Prior to contract termination.
2.A. Assessment	**Assessment:** When a client accepts services, the Social Worker/Therapist, a qualified and certified staff member conducts the CFS Comprehensive Basic Assessment and begins planning for the Individual Program Plan (IPP) together with the family in a strengths based and family-centered manner. Specific questions on the assessment form engage clients to share cultural strengths, support systems and other strengths the clients can draw upon in their situation. The family is an active and integral part of the process, and is asked to assess their own strengths and needs and to really make them feel included on the assessment process. Clarifying questions are suggested and encouraged. The Social Worker/Therapist gives pre-eminence to the family's understanding of the facts and conveys to the family that they believe the family without judgment. Specific questions from the assessment are designed to engage families and discover what the family wants, recognizing they are the experts of their own family. The worker conducts the assessment using an approach that is more informal, such as talking story, rather than the traditional question and answer approach. Through stories, both the adults and their child(ren) are encouraged to share with one another about their family values and beliefs presently and during their own upbringing. The families also explore cultural strengths,	Social Worker/ Therapist is responsible for the Assessment, IPP, and case management. Back up: Program Administrator	Completed during first three home visits within 30 days of intake. If the family is in crisis, the assessment is completed concurrent with crisis intervention.

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	cultural family roles, support systems and unique qualities that are utilized to build resiliency and strength within the family. For example, culturally, it can be challenging to identify and speak about one's own strengths, so asking the child(ren) or other family members, "what makes dad a great father?" or "what is he really good at?" is used. Parents are usually surprised to hear how highly their children and family thinks of them. This can boost the father's confident and even encourage further engagement and belief in the process. The assessment is provided to the CWS staff upon request and at their discretion. Many of the goals addressed in this assessment process are supported by the CWS staff. As we work collaboratively the family will see their input as helpful and constructive and see that the team is there to support their needs. Admitting areas of concern is not seen as a weakness or fault but as an area where support and resources can be given to equip the families with the tools they need to be successful. When the request for service/assessment exceeds program capacity, families from DHS are given priority and CWS unit supervisors prioritize the cases to be assessed. If support is needed Section Administrators or Program Development can also be consulted to ensure a smooth and fair process is being conducted. CFS will be sure the lines of communication are clear and that expectations and needs are being met. All assessments must include a determination of child safety. Also as part of the assessment process is the use of **Safety Assessment** for the family. Ensuring placement safety is a growing area of concern that the program supports the Department in accomplishing. The program will also include other assessments as specified by the Department. For crisis intervention activities, services start immediately. Assessments, if requested, are completed concurrently with the activity. The CFS Comprehensive Basic Assessment form includes but is not limited to following areas:		

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	a. Presenting problem from the family's perspective b. Current services and previously utilized services c. Family and individual strengths, resources, and support systems including upbringing d. Family and individual cultural characteristics, values and strengths e. Psychosocial issues f. Safety issues such as family distress g. Legal concerns/issues h. Living conditions i. Educations and vocation status j. Health history k. Substance use history l. Mental health information m. Special needs n. Assessment summary o. Recommendations After exploring the family's strengths and supports, the Social Worker/Therapist discusses with the family the areas they want to improve upon. The Social Worker/Therapist offers to contact current familial support systems in order to gain a better understanding of the concrete supports that the family currently have in place. Staff utilize the CFS Alcohol and Substance Abuse Screening Tool and CFS Mental Health and Mental Status Screening Tool as a resource to assist in the assessment of needs. Current established mental health and/or substance abuse service providers are also consulted after obtaining consents from the family, to evaluate any additional needs. The assessments help to support the families to realistically assess their ability to protect children and the areas that they may need to improve or that need support. For some this is an enlightening process, the staff members create such a positive atmosphere of support that they are able to be honest and open. From our initial contact to case closure the client is made aware of the disposition of the referral. Together any and all appropriate		

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	service activities are determined within the scope of the PSS Program for the family. The program also implements other assessments as specified by the Department.		
2.B. Other Assessment Tools	At intake the program administers **the Adult-Adolescent Parenting Inventory-2 (AAPI-2),** an inventory designed to assess high-risk parenting attitudes. The answers from the inventory assist the Social Worker/Therapist or Child Development Specialist and the family with assessment and with developing the IPP. It provides a concrete measure to share with the parents on areas that need improvement as well as what areas are strong. The answers to the 40 questions on the inventory provide an index of risk in five specific parenting and child rearing behaviors: a. Inappropriate expectations of children b. Parental lack of empathy toward children's needs c. Strong belief in the use of corporal punishment as a means of discipline d. Reversing parent-child role responsibilities e. Oppressing children's power and independence A Likert Scale developed with the family based on the issues identified by the AAPI-2, family, and referral source measures the family's level of concern. The family reassesses itself at the end of the services on the Likert Scale.	Social Worker/ Therapist Back up: Program Administrator	Typically started at the 1st home visit and again at case closure.
	The Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) Also when applicable (depending on age of child) program staff will administer the Ages and Stages Questionnaire (ASQ) to assist the families in knowing if their young child is developmentally on target. The ASQ is a screening tool that covers five domains plus a section for general concerns. This tool is utilized in order to determine if any of the children in the home are developmentally delayed. These domains include: • Communication (Language skills)	This is primarily done by the CDS but can be done by the Social Worker/Therapist Back up: Program Administrator	Done within the appropriate widow period of child developmental milestone.

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	• Gross Motor (Large muscle strength, movement and coordination) • Fine Motor (Hand and finger strength, movement and coordination) • Problem Solving (Playing and figuring things out) • Personal-Social (Interaction with toys and people and the development of self-help skills) • Overall (General questions about health and any concerns) The CDS assists the parent in using the Ages and Stages Questionnaire (ASQ), Hawaii version, to assess the child's developmental progress in each of the five domains. The ASQ identifies all children up to age of 6, scoring in 3 ranges: • "Routine Monitoring" for children who seem to be developing as expected; • "Follow-Up" for children who are developing more slowly than expected; and • "Referral" for children whose performance seems to be significantly slower than expected. The Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) is a screening tool that identifies infants and young children that may need their social or emotional development further evaluated to determine if referrals for intervention services is necessary. Critical to the well-being of children is their ability to regulate their emotions and manage their social interactions with others in ways that are appropriate. The ASQ-SE addresses seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people. The CDS explains the results of the ASQ/ASQ-SE screening to the parents, answering any questions they may have. Additionally, parents are supported and encouraged to seek services for their child when needed. The results of the ASQ/ASQ-SE are sent to the child's health care provider as long as parental consent is obtained.		

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	Vineland Adaptive Behavior Scales which assess the performance of the daily activities required for personal and social sufficiency is also used as applicable. Adaptive behavior is defined by the expectations or standards of other people and typical performance, not ability. This tool has been very helpful for children/youth in the past.	Social Worker/ Therapist or CDS Back up: Program Administrator	Completed only as deemed necessary. The scale is used when there are concerns of behavioral, developmental and social problems.
3. In-Home Crisis Intervention Services	The focus of home-based crisis intervention services is to prevent the out-of-home placement of the child, where appropriate. PSS staff has worked with many families with great success. There have been a very select amount of cases where out-of-home placement has been necessary but these decisions are usually made with a team of experts with the support of PSS. Kahi Mohala has been very instrumental with some of these more recent disruptions. Upon receipt of referral, the PSS staff contact the referred family within one business day to schedule an initial assessment. In cases of crisis, intervention starts immediately and use of some assessment tools are delayed until immediate crisis has been addressed. Service components may include: • Assessment • Counseling • Case management • Role modeling and/or mentoring • Education, especially in the area of child development. Detailed in the narrative some of the more serious problem areas are highlighted that we have seen throughout the years. The narrative also explains how intervention is made through our direct service provision in these areas. PSS works with the family on an individual basis taking into account their unique needs but these interventions are just a guide to work from.	Social Worker/ Therapist Back up: Program Administrator	Available to the clients 24 hours 7 days a week. Up to three months, with monthly extensions approved by DHS social worker.
4. Individualized Program Planning Called **IPP (Individual Program Plan)** in PSS	With CWS-referred families, the family, the PSS Social Worker/Therapist and other team members, and the CWS social worker will collaborate, develop, and sign off on an Individual Program Plan (IPP). Their support in the assessment phase will make a smooth transition in setting goals everyone can agree on. The IPP contains goals and objectives that are consistent with the CWS family case plan and incorporate the concerns of the CWS	Social Worker/ Therapist Back up: Program Administrator	Within 30 days of intake unless otherwise documented due to special circumstances but only after assessment is complete.

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	social worker, the family's needs, and the information obtained during assessment and the AAPI-2. To determine the IPP, a telephone consultation or a face-to-face case conference is held no later than one week from the date of referral. Working together as a team is not necessarily time consuming and in many cases working on the same page from the start of the case has actually saved time in the long run. The consultation or conference must include the input of the client(s), the CWS worker, and the provider and every effort is made to be sure that everyone feels comfortable to share their views and that no one party is dictating the outcome of the meeting. The consultation or conference shall result in an IPP signed by the child/youth (if age appropriate) and family/caregiver. CWS social worker, and provider to determine the services that will be provided when possible. Every opportunity is given for the CWS worker to participate but if and when that is not possible a plan is sent to them for their review and signature. Non-CWS referrals are conducted in the same collaborative manner with the family, and with the other referral source, if appropriate. An IPP is developed and signed by the family and the PSS staff. Start and end dates for all services is documented on each IPP. Discharge summary plans are discussed at this early intake process so the team is aware of the end goal and is planning for this purposefully from the start of services. The plan is reviewed, updated and revised as needed quarterly.		
5. Case Management	The PSS staff accepts referrals, documents the activity requested, and obtains any needed documents from CWS workers. They also coordinate and manage services to achieve established goals. Case conferences are scheduled as requested by CWS staff and include the revision of the IPP. Meetings will be scheduled at a place and time convenient to CWS staff and families, to the greatest extent possible. Families are included whenever feasible	Social Worker/ Therapist, CDS (has more regular contact with the family once the assessment and IPP is completed) or FSW both with support and under the direction of the Social Worker/Therapist.	Beginning at intake and ongoing throughout as needed. One to two hours weekly or more, depending on the family's needs.

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	and appropriate. These conferences and meetings may be held in person or via conference call. Any case with clients involved in, or in need of, sex abuse treatment are referred to, and include, the POS sex abuse treatment provider. With DHS and family consent, PSS workers coordinate and cooperate with the POS provider so that PSS Program planning activities are well coordinated and consistent with the sexual abuse treatment plan. Upon receipt of referral, the PSS staff contact the referred family within two business day to schedule an initial assessment.	Back up: Program Administrator	
6. Counseling Service	Services are often appropriate to achieve desired goals and outcomes. They are intensive and focused on issues that present risk to the child or children. Services are flexible and accommodate parents' work schedules by occurring after hours and/or weekends. Services may be provided either in or outside the family home, depending on the preference of the family. Services may be 1 to 2 hours weekly or more depending on needs of the family. If the child/youth or family/caregiver is assessed to need long-term counseling outside the scope of services that this contract is able to provide, referrals for more appropriate services are made. Counseling services will exclude situations involving sexual abuse; these are referred to the agency under POS contract with DHS to provide these services. Counseling services may include, but not be limited to: **Clinical therapy/counseling** – Social Worker/Therapist can provide solution focused interventions. Hourly in-home therapeutic services can be offered. If the child/youth or family/caregiver is in need of intense-long term clinical therapy/counseling a referral is made for outside support. A list of therapists that specialize in attachment and other specialist areas is kept by the program as possible leads for the family for follow-up. Criteria on what the therapist's service philosophy would entail may be reviewed so the family can make an informed decision on appropriate counseling services.	Social Worker/ Therapist and CDS Back up: Program Administrator Social Worker/ Therapist Back up: Program Administrator	Within 30 days on intake and completed after the assessment unless otherwise documented due to special circumstances. As needed.

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	Supportive counseling – Social Worker/Therapist and Child Development Specialist can provide brief counseling sessions using these techniques: Listening actively, giving advice, adding perspective, confirming the appropriateness of the family's concerns. They can empathize with the family/individual, while moving the dialogue toward the construction of clear, simple and specific actions to solve their concerns.	Social Worker/ Therapist and CDS Back up: Program Administrator	Weekly or as needed.
	Problem-solving skill building – Social Worker/Therapist can assist families in gathering facts to better solve their problems. Problem-solving techniques can be used to help them replace negative thoughts with practical solutions. Hands on worksheet, brochures, books, role playing, videos, and other tools are available. CDS or FSW may practice the applications with the families once the initial instruction has been done by the Social Worker/Therapist.	Social Worker/ Therapist, CDS and FSW Back up: Program Administrator	
	Communication skill building – The Social Worker/Therapist can do the initial discussions and can work with families and couples on building their communication skills. Interventions include teaching active listening skills, being aware of non-verbal communication, using I statements and other practical tips. They may use worksheets, role playing, modeling how to have family meetings, games, brochures, books, videos or any other activities that help the family build their skills. CDS or FSW may practice the applications with the families once the initial instruction has been done by the Social Worker/Therapist.	CDS and FSW Back up: Program Administrator	Weekly
	Coping skill building – The Social Worker/Therapist or CDS can assist families in developing and monitoring coping strategies by: 1. Identifying two to three coping strategies that are consistent with their personality and lifestyle. 2. Creating a list of coping strategies for the family/individual to use. 3. Providing regular follow-up on what worked and what didn't and reworking the list of strategies.	Social Worker/ Therapist or CDS Backup: Program Administrator	Weekly

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	The Social Worker/Therapist or CDS can work on activities that help the family/individual relax. They may use worksheets, role playing, modeling, games, brochures, books, videos/ DVDs or any other activities that help the family build their skills. FSW may practice the applications with the families once the initial instruction has been done by the Social Worker/Therapist or CDS.		Weekly
	Child behavior management training – CDS can provide the family with hands on practical application of behavior management training. The CDS can model for the parent techniques like praise, clear choices/consequences or reward charting and supporting parents in the implementation of some of the suggestions. The FSW may provide support in practicing some of these techniques that have been previously covered by the CDS.	CDS and FSW Backup: Program Administrator	
	Education on child development – ASQ/ASQ-SE are great tools for the CDS to help parents of young children identify areas of possible developmental delays. Developmental curriculum and activities are utilized to provide information on typical childhood development and to assist parents in becoming more knowledgeable about typical child development. FSW may provide support in practicing some of these techniques that have been previously covered by the CDS.	CDS and FSW Backup: Program Administrator	
	Awareness of the norm helps parents have realistic expectations that are age appropriate thus resulting in less disappointment by the parents and increased success for child(ren). Focus on acknowledgement of the parents' desire to help the child be the very best person that he/she can become, is one positive reframing of concerns about potential delays. The Family Service Worker or CDS will be supportive by helping to facilitate acceptance of the child's need for services if it is needed or to allow the child room to develop at their own pace if intervention is not deemed necessary. The ASQ/ASQ-SE tools are accompanied with many great activities that enhance growth and development. The CDS has many other tools to support families in increasing their knowledge of child development and well-being. They are able to		PRE: Within 30 days on intake and completed after the assessment unless otherwise documented due to special circumstances. POST: During discharge.

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	do hands on activities with the families. The Family Service Worker is also skilled at supporting both the CDS and the family. Brochures, books, videos, games, art projects and physical activities are used on a regular basis. The PSS library has grown over the years. **The AAPI-2** helps parents identify specific parenting skills they may be interested in improving. The CDS or the Family Service Worker reviews educational brochures, workbooks, worksheets, videos, plays games, models appropriate behaviors and uses other creative tools as part of parent education. The intervention is based on the client learning modality. AAPI-2 curriculum and activities for the specific areas are used. Positive parent-child interaction is often achieved through increasing parental empathy through child development education. Parents begin to recognize that a positive environment with affirmations will have a positive and encouraging effect on the child(ren). Curriculum for teaching and modeling of positive parent-child interaction activities provide practical instruction in developing warm and nurturing parent/child relationships. For some mothers as well as fathers, the simple knowledge that improved bonding will simplify their task of parenting is an effective motivator; for others it will be the desire to see their child grow and flourish rather than just survive. Positive parent-child interaction information also includes appropriate options for disciplining a child including the setting of clear limits by the parents, how to access social and professional supports for assistance and advice, and how to be empathetic. Recognition by parents of the emotions and feelings experienced by their child(ren) is very important for the prevention of child abuse and neglect. Increasing parental empathy is significantly challenging. Much reframing is needed to move a parent from the perception that a child is behaving in a particular manner to "get at the parent," to an understanding of what the child is actually feeling and experiencing. The move from a parent's self-centered perception to a child-centered perception is imperative, if the parent is to feel empathy for the child. Without empathy, a parent will be unresponsive at best and abusive at worst. Continued lack	Social Worker/ Therapist, CDS and FSW Backup: Program Administrator	

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	of response by parents to the child's emotional needs is very discouraging to the child (Adler) and at the root of many inappropriate behaviors that children demonstrate in their preschool and school years.		
7. Parent Groups and Training	Parent groups and or conferences for professionals and families are provided and/or supported. The training component provides educational opportunities for permanency families and professionals on permanency and therapeutic parenting related topics. CFS has the expertise to organize and conduct conferences. For more than eight years PSS at CFS has collaborated on very successful conferences that were well attended by both parents and professionals through HAPA with Local and National speakers. The goal is to improve parenting skills and to help professionals provide better assistance for permanency families as well as develop and strengthen their knowledge on current permanency issues. Through training, the PSS Program works to develop a network of multi-disciplinary professionals that specialize in permanency issues. PSS staff members understand that typical parenting strategies don't work on children and youth who have been traumatized at some point in their life. PSS staff members have attended trainings, researched the topics and sought out the most current information on this topic so that they can provide the families with the most up to date information that will make a difference in the family's life. This information is included in trainings to support the placement of the child/ren. These activities include: • Parenting groups or conferences to enhance knowledge of child management skills and normal child development stages by using simple, concrete techniques taught in a group format. • Educational materials and skill building exercises as well as role playing of appropriate parenting strategies and interventions are used during the sessions. These groups focus on a variety of topics, including identifying Fetal Alcohol Syndrome/Effects, Drug Exposure in Utero, Reactive	CDS and FSW will take the lead on parent groups and will also take the lead with collaborative partners for joint training and groups and Social Worker/Therapist will provide more in-depth workshops as needed. Back up: Program Administrator	To begin at referral and continue throughout service, as appropriate. HAPA conference will be done annually as funding permits but parenting groups and small training will be done regularly and as interest by clients is maintained.

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	Attachment Disorder, Grief & Loss in Adoptions, Communicating with Teens, Building Support Networks and other pertinent topics as identified by the families serviced. Parents are provided not only with educational materials but also have the opportunity to network with other parents dealing with similar issues. These groups allow parents to increase their support system and share ideas and challenges with other families who truly understand what they are going through. • During the parent groups/conferences, teen and child groups are offered as well. This allows the entire family to come together and participate in activities designed for each age group. Younger children can do arts and crafts and play with various educational toys. Teens can participate in therapeutic adventure based activities designed to build their problem solving-skills, improve their self-esteem, increase their ability to communicate effectively, and build their own support network of friends. The parents, teens and younger children have the opportunity to come together at the end of the groups to share with one another their experiences and lessons learned. The children and teens receive handouts on the activities that they participated in, allowing them to do the activities and exercises again, at home, with their family or friends. • Parenting groups or conferences will be offered for parents with substance abuse problems to encourage and facilitate the parents' understanding of the effect their substance abuse has on their children, and to support, encourage, and facilitate parental participation in substance abuse treatment. • Socialization groups are offered to develop concrete, everyday problem solving abilities as well as learn how to interact with other people more productively.		

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8. Permanency Information and Referral	Permanency information, referral, and outreach is provided to all families throughout the course of services. This is accomplished through the following array of activities: Provision of family, group, and/or individual counseling are based upon goals agreed upon in the IPP. • Psycho-Social interventions • Referrals to community based services • Home visits • PSS staff attending Resource Family community events	This is primarily done by the CDS and FSW both with support and under the direction of the Social Worker/ Therapist. Back up: Program Administrator	Beginning at intake and ongoing throughout as needed. One to two hours weekly or more, depending on the family's needs.
8. a. Permanency website Permanency Information and Referral	**Permanency website:** A comprehensive permanency website that contains resources, referrals, fact sheets, a statewide training calendar, and other information to help families and enable professionals to better support families will be added to the existing CFS website. CFS will ensure website maintenance and computer and technical support, including domain name, URL forwarding, internet service provider, web hosting, and report statistics on page views, visitors, referrals, popular pages, guest book, message board, and web hosting will be done professionally and on a regular basis.	Web Master and Communications Coordinator Backup: CFS IT Dept.	**Permanency website** updates will be done at least monthly.
8. b. Phone line Permanency Information and Referral	**Phone line:** A phone line with voicemail is available on Oahu to callers 24 hours a day, 7 days a week. PSS staff answer questions from families, professionals, and others interested in adoption or legal guardianship and refer them to appropriate resources in the community. CFS works with the existing Warm Line and The Parent Line to ensure that these types of calls are referred to the program. Program has clear protocols on how to handle these calls. CFS has extensive experience in operating phone line services.	All PSS staff are responsible for returning calls to the Phone Line.	**Phone Line** calls are answered within one business day. A pager is used for staff to be on call.
8. c. Directory of agencies, professional services, trainings, and other resources. Permanency Information and Referral	**Current directory:** Includes agencies, professional services, trainings and other resources.	All PSS staff are responsible for maintaining and updating directory. Program Secretary to maintain.	New resources are added as they become available.

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
8. d. Resource lending library Permanency Information and Referral	Resource lending library located at the Vineyard office: **This is open to all permanency families which include books, tapes, videos, self-study courses and information packets. Included on our service delivery section are some of the materials we also use during our interventions with the families that will be in our resource lending library as well.**	All PSS staff are responsible for maintaining and updating library. Program Secretary to maintain.	New resources are added as they become available funds permitting.
9. Child-centered pre- & post-permanency activities	During family visits, staff use workbook materials, art therapy and "therapeutic" games to build rapport with the child(ren) and to reduce the child's anxiety about the permanency process. During parent support group activities, the child is engaged in crafts and other activities with other children (preferably developmentally matched) as a means to normalize and discuss their permanency experience. Through this play therapy, the staff seek to improve the connections between the child(ren) and the parents by giving the child(ren) a common language with which to communicate with their parents and other adults.	Social Worker/ Therapist, CDS or FSW Backup: Program Administrator	Ongoing as needed for duration of treatment.
10. Reporting and documentation of case status & client progress	Reporting and documentation includes progress notes, case status reports, significant event reports, quarterly case summaries, discharge summaries, Quarterly Activity Reports (QARs) and other documentation necessary to monitor and evaluate the quality, quantity and timeliness of the services provided. The written reports are in a Department approved format. **Progress Notes:** Each contact with a family, referral source, or other entity involved with a particular case is documented in a progress note and included in the case file according to COA standards. Notes are in the file within 24 hours of the visit or contact made. Quarterly reports are sent to POS monitor on the progress of the families, program statistics, and area of concern or highlights in a formal report. Narratives and individual success stories are shared in these reports. Some of this information will also be shared at the CW CQI meeting which includes other community partners. **Discharge summary** described in detail above in 1.D. Discharge criteria & process.	All PSS staff are responsible for maintaining and updating all case documentation and client progress as they work on the case.	Documentation occurs after the service is provided within 24 hours.

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
	Quarterly case summaries and **Quarterly Activity Reports** described in detail below in **14. A.** Connect and coordinate with CWS and other sources of support.		
11. Connect and coordinate with CWS and other sources of support	**Case Status Reports and coordination with CWS:** As with the DHS, PSS' primary goal is safety, permanency and well-being for the children and families. PSS works closely with DHS-CWS workers on services, goals and outcomes for clients. Updates from the CFS-PSS worker to the DHS-CWS Permanency worker or Case Manager about a client's progress is done on an ongoing basis as requested or applicable. Close contact by telephone, fax and email between CFS worker and CWS worker keeps all parties current on client progress in an effort to monitor and evaluate the effectiveness of service delivered. PSS will work closely with DHS-CWS permanency workers on services, goals and outcomes for clients. A quarterly report is also sent to keep the worker up to date with the case on a regular basis. Quarterly reports will be sent to POS monitor on the progress of the families, program statistics, and areas of concern or highlights in a formal report. Narratives and individual success stories are shared in these reports. Some of this information will also be shared at the CW CQI meeting which include other community partners. PSS cooperates and is flexible with DHS as requested to implement changes to the program and will participate in quality assurance/improvement projects as requested by DHS for research and evaluation purposes. Program records will be provided as requested by DHS as well.	Social Worker/Therapist Back up: Program Administrator	
12.a. Quarterly Activity Reports (QAR) Evaluate program effectiveness	**Quarterly Activity Reports (QAR)** contain: information on program progress that quarter from the indicators on Forms A, B, C; major accomplishments that quarter; training provided using Title IVB, Subpart 2 funds; problems encountered and corrective actions taken; staff changes; plans for the next quarter; referral sources; and other significant information about the program for that quarter.	Social Worker/Therapist Backup: Program Administrator	Due to POS Monitor within 30 days of end of fiscal quarter.

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
12.b. Assessment tools Evaluate program effectiveness	Results from the **Adult-Adolescent Parenting Inventory-2 (AAPI-2)**, the **Ages and Stages Questionnaire (ASQ)** and **Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)** also help the program evaluate the program's effectiveness.	Social Worker/Therapist, CDS Back up: Program Administrator	Results from the AAPI-2 are reviewed as part of the discharge summary.
12.c. Discharge Summaries Evaluate program effectiveness	**Discharge Summaries** document the client's progress during the length of the case. Includes an aftercare plan if needed which identifies the continuum of other services needed or desired by the family/caregiver, and which specifies the nature and frequency of follow-up or aftercare contact by CFS (if needed). These results also help the program evaluate its effectiveness. Changes are made to the program based on how clients are doing at discharge.	Social Worker/Therapist, CDS Back up: Program Administrator	Discharge Summaries are entered in the client's record no later than 30 days following discharge.
12.d. Client Satisfaction Surveys Evaluate program effectiveness	**Client Satisfaction Surveys** are distributed at discharge. Additionally, client satisfaction is discussed during quarterly IPP update.	Social Worker/Therapist, CDS Back up: Program Administrator	Given to family at discharge.
12.e. Referral Source Surveys Evaluate program effectiveness	**Referral Source Surveys** are distributed to the referring CWS social workers and other referral agencies in order to provide a formal opportunity for stakeholders to express their views with regard to designing, reshaping, and redefining existing services. Additionally, stakeholders are encouraged to identify barriers that prevent access to any group of individuals. Feedback from stakeholders is aggregated and utilized to improve management strategies and service delivery practices.	Program Secretary Back up: Program Administrator	Distributed bi-annually.
12.f. Consumer Satisfaction Phone Calls Evaluate program effectiveness	**Consumer Satisfaction Phone Calls** Program Administrator conducts quarterly phone calls to a random portion of discharged and open cases. The information gathered from the client satisfaction phone calls is used to identify program strengths and weaknesses as indicated by program consumers. Information from this survey is complied into one report and shared during staff meetings with the entire staff. Information is also provided to individual team members and is used during their annual performance reviews. Feedback from all of these surveys is discussed with program staff during supervision, annual reviews and/or staff meetings as well as during the CFS quarterly PQI process. Sharing this important information allows PSS Program staff to self evaluate and take ownership of program improvements. The PSS Program staff take	Social Worker/Therapist Backup: Program Administrator	Calls made quarterly to three of each staff members' families.

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
	great pride in offering flexible, adaptable, responsive and cooperative customer service and problem solving solutions at the program level with not only our families but also with our collaborating partners and with DHS-CWS.		
12.g. Supervision- Monitoring productivity and accurate documentation and reporting Evaluate program effectiveness	Documented and filed supervision and case supervision with PSS staff is completed on a monthly basis and at a minimum, quarterly and prior to case closure. During supervision as well as throughout each week, the client database and all case files, daily and weekly tracking logs/charts, calendars and schedules are discussed and reviewed to ensure proper service delivery, documentation, reporting, outcomes and tracking. The supervision document is detailed and identifies the status of progress with service goals for the family as well as any action plan needed to be taken by staff. The Program Administrator and Program Administrator are also available twenty four hours a day seven days a week for case consultation or for crisis situations.	Social Worker/Therapist Backup: Program Administrator	Supervision is done twice a month.
12.h. Peer Case Record Reviews Evaluate program effectiveness	PSS also participates quarterly in a case record review and PQI process with other CFS programs which assists with the identification of areas of success and areas in need of improvement. Through this process as well as through staff meetings and individual supervision, goals are established with action plans for areas of improvement and are reported to upper management quarterly. These action plans are reviewed during the following quarter and reported on as well. The PSS contracts will work with the Department and will be prepared for annual contract monitoring that may include site visits with comprehensive evaluation of several areas of performance. PSS will ensure that the program is in conformance with standard contractual requirements, agency files, accounting practices, and case record keeping. PSS will also participate in quality assurance/improvement projects as requested by the Department for research and evaluation purposes. Staff will complete one (1) Hawaii Child and Family Services Review (CFSR) per year, per qualified staff as requested and arranged by the Department. Other quality assurance/improvement activities shall include data collection and	All CFS program staff	Peer case record reviews are done quarterly.

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
	other future request related to current Department initiatives, activities and programs. PSS will provide records for review by the Department for these purposes		
12.i. Program Outcomes Evaluate program effectiveness	**Program Outcomes** as outlined by CWS are used for program evaluation. These include: • % of families with no confirmed reports of child maltreatment during program services: 95% • % of families without placement disruption during program services: 95% • Number and % of international adoptions that disrupt during program services • % of families receiving intensive in-home services that demonstrate progress toward treatment goals: 80% • % of children demonstrating improvement in the attainment of developmental milestones: 80% • % of adoptive parents, legal guardians, and/or permanent custodians seeking information and/or referral to permanency resources that receive assistance: 100% • % of adoptive parents, legal guardians, and/or permanent custodians reporting satisfaction with seminars, workshops, and training: 80% • % of service providers reporting satisfaction with seminar, workshops, and training: 80% Reporting Requirements: Quarterly reports are sent to POS monitor on the progress of the families, program statistics, and area of concern or highlights in a formal report. Narratives and individual success stories are also shared in these reports. Some of this information will also be shared at the CWS CQI meeting which includes other community partners.	Social Worker/Therapist Backup: Program Administrator	Outcome collection is ongoing throughout the course of the program. A summary and report is provided to CWS quarterly.
GENERAL PROGRAM REQUIREMENTS:			
13. Minimal English and physical limitations	**Minimal English:** If any individuals in the family have limited English speaking skills, CFS will attempt to find internal agency staff not assigned to the program to provide translation services. If no organization staff can be located, the Permanency Support Services staff will contact the Bilingual Access Line for	Social Worker/Therapist Backup: Program Administrator	Assessment begins with first family contact.

Service Activities, Outcomes, Assurances	Specific Tasks	Staff Responsible (Title/Position)	Timeline/ Schedule
	assistance. Program funds will be used to pay for this service. **Physical limitations:** Permanency Support Services are provided to families in their home or other place in the community that is convenient for them and safe for both the family and worker. For vision or hearing impaired individuals, special assistance is sought in order for the family to receive full benefit from the program.		Family needs are determined starting at first visit.
Criminal History Checks	**Criminal history checks:** Below are the procedures that are employed to implement these requirements: Once an employment offer is tendered, criminal history checks are conducted for new direct service employees. An offer of employment are withdrawn or the position of a direct service provider is terminated when a prospective or current direct service provider has a criminal conviction as indicated below: • The criminal conviction occurred within the last 10 years; and • The crime for which there is a conviction has a rational relationship to a direct service provider's position.	The Human Resources Dept. (H.R.) Employment Assistant is responsible for monitoring this requirement. Back up: H.R. designee.	Both background checks are completed upon hire; then 12 months later; then thereafter every two years.
CPS Registry Checks	**CPS Registry checks:** Below are the procedures that is employed to implement these requirements: Once an employment offer is tendered, a check is conducted via the Adult and/or Child Protective Services Central Registry for new direct service employees. Unfavorable findings do not necessarily result in the employee's dismissal and are reviewed on a case-by-case basis and with the following criteria: • The nature and gravity of the offense. • The amount of time that has passed since the offense. • The nature of the position in question. **Note:** No applicant who has a record of criminal conviction or CPS involvement that would pose a risk to health, safety, or well-being of families is employed by the Permanency Support Services Program.	The Human Resources Dept. (H.R.) Employment Assistant is responsible for monitoring this requirement. Back up: H.R. designee.	Both background checks are completed upon hire; then 12 months later; then thereafter every two years.

2. *The applicant shall provide a projected annual timeline for accomplishing the results or outcomes of the service*

   See timeline for specific service activities in above Work Plan.

3. *The applicant shall describe its quality assurance and evaluation plans for the request. Specify how the applicant plans to monitor, evaluate, and improve their results*

   CFS is dedicated to providing quality services to the individuals and families it serves, and to be accountable to those who fund the services. CFS has well established Performance and Quality Improvement (PQI) mechanisms. PQI is an ongoing process that occurs daily as staff members strive to improve the service they provide internally and externally. On a quarterly basis, the organization-wide committees meet to review aggregate data, and program and administrative staff review their outcome data, identify their strengths, discuss compliance issues, and troubleshoot areas of concern.

   As part of the PQI process, programs are asked to identify how they monitor, measure and collect data on performance measures and outcomes. Each program completes the Quarterly Manager's Report (QMR) that identifies quality indicators which include:

   - Number of clients served (unduplicated)
   - Client outcomes
   - Case record reviews
   - Utilization review
   - Client satisfaction
   - Referral source satisfaction
   - Client grievances
   - Supervision
   - Training
   - Accomplishments and strengths
   - Progress on any action plans

   The data gathered for this report is reviewed with staff members by the supervisor during regular staff meetings. The trends identified are discussed and an action plan is developed. This process allows all staff to participate in the PQI process and provides accountability that the expected outcome is achieved.

   The QMR is a tool for programs to track and validate effectiveness of the activities or services provided. The tool identifies trends, strengths and areas for improvement. It allows programs to identify and resolve problems, make improvements to the program development plans, and identify staff roles and responsibilities.

   The quality assurance and evaluation process within the PSS Program consists of several approaches to ensure consistent, thorough and high quality delivery of services to families, collaborating service providers and the Department of Human Services. Satisfaction surveys are sent to referral sources and families. The PSS Program

Administrator contacts families quarterly for telephone surveys as well. All surveys are reviewed by the Program Administrator and the information is relayed to PSS staff and also documented in CFS quarterly reports and DHS quarterly activity reports. The feedback received from these tools allows the program to evaluate and improve services.

The PSS staff meet, review and develop action plans in response to the surveys. As a result several improvements have been made. Some of the clients reported they did not find the groups helpful. The staff looked at the content of the groups and the comments from the families and caregivers and made changes to the groups. The staff looked at the topics offered and the suggestions made by the caregivers. One example is some of the caregivers reported struggles with attachment issues. The staff then developed materials and resources on attachment issues. This brought some of the caregivers closer together and they were able to offer support to one another and work through some of the challenges that they were struggling with. The families reported this was very helpful and they felt tremendous support. Resources have been added to our library to for the families as a result of suggestions made.

The staff has been going to Kahi Mohala, the psychiatric institute, to offer the support to the families/caregivers when the children/youth are hospitalized. Often the families/caregivers express anxiety about going to the facility and are not sure what to expect. The PSS staff have been able to offer more support and reduce stress to the families and caregivers by accompanying them.

Supervision with staff is another means of quality assurance and evaluation. Staff receives bi-monthly supervision to review professional and personal goals as well as case supervision to review the status of PSS referred family goals and progress. Case files are reviewed and the supervisor documents in detail the needs and status of progress for the family as well as the needs for the actual case file. Various tracking methods are utilized by staff, and reviewed by the supervisor in order to accurately track and supervise outputs, outcomes, client hours and documentation requirements.

PSS also participates quarterly in a case record review and PQI process with other CFS programs which assists with the identification of areas of success and areas in need of improvement. Through this process as well as through staff meetings and individual supervision, goals are established with action plans for areas of improvement and are reported quarterly.

The PSS contracts will work with the Department of Human Services and will be prepared for annual contract monitoring that may include site visits with comprehensive evaluation of several areas of performance. PSS will ensure that the program is in compliance with standard contractual requirements, organization files, accounting practices, and case record keeping. The PSS Program will be sure all ongoing contract monitoring such as review of monthly and quarterly reports and periodic assessment of program effectiveness is in place.

PSS will also participate in quality assurance/improvement projects as requested by the Department of Human Services for research and evaluation purposes. Staff will complete one Hawaii Child and Family Services Review (CFSR) per year, per qualified staff as requested and arranged by the Department of Human Services. Other quality assurance/improvement activities shall include data collection and other future requests related to current Department initiatives, activities and programs. PSS will provide records for review by the Department of Human Services for these purposes.

The results from the Adult-Adolescent Parenting Inventory-2 (AAPI-2) and the Ages and Stages Questionnaire and Ages and Stages Questionnaire: Social-Emotional (ASQ and ASQ-SE), also help the program evaluate the program's effectiveness.

Tracking ongoing services is an integral part of the quality assurance system for the PSS Program. Accurate tracking provides for an ongoing needs assessment of the clients being served. For example, by tracking the number of families being referred to a particular service the program becomes aware if there is an increase in clients and may adjust services or establish partnerships to meet the needs of the clients. Various trainings for staff and supports to clients can be modified to ensure the most up-to-date information is available. In order to track accurately, all of these numbers are recorded over time for each client utilizing a client tracking sheet. A quarterly worksheet is also utilized for tracking purposes. During supervision the tracking sheets are reviewed quarterly by the Program Administrator and are consolidated for inclusion in the quarterly report.

4. *The applicant shall list the measure(s) of effectiveness that will be reported to the State agency through which grant funds are appropriated (the expending agency). The measure(s) will provide a standard and objective way for the State to assess the program's achievement or accomplishment. Please note that if the level of appropriation differs from the amount included in this application that the measure(s) of effectiveness will need to be updated and transmitted to the expending agency.*

Performance Outcomes/Output Measures

People to be Served

1) 30 families will receive direct services.
2) 78 adults will receive direct services.
3) 110 children will receive direct services.
4) 10 families will receive adoption assistance (2 Federal and 8 State).
5) 20 families will receive permanency assistance.
6) 4 international adoptions will occur.
7) 2 out-of state adoptions will occur.
8) 7 other adoptive families will be served.
9) 20 other permanency families will be served.

CFS has a strong monitoring system that ensures adequate and accurate tracking of client contact and services. Staff accurately track the number of referrals that the PSS program receives. Most referrals to PSS will come from CPS. At the end of each quarter or as

requested by the CPS Social Worker, an update on client goals and progress will be sent to the CPS Social worker for all open CPS cases. For all families (self referred, referred from other community organizations, CPS referrals), data on the number of families, adults and children will be indicated on a quarterly report.

Service Activities

1) 35 families will receive assessment services (30 CWS, 5 non-CWS).
2) 35 families will receive in-home crisis intervention services (30 CWS, 5 non-CWS).
3) 30 Individualized Program Plans will be completed.
4) 110 child safety plans will be implemented.
5) 78 individuals will receive case management.
6) 30 families will receive case management.
7) 75 individuals will receive individual counseling.
8) 25 families will receive family counseling.
9) 20 individuals will receive group counseling.
10) 10 trainings, workshops and seminars will be offered to permanency families on permanency issues.
11) 10 trainings for 75 individuals will be provided to professionals on permanency issues.
12) 70 trainings, workshops, and seminars will be provided to members of international adoption triads on permanency issues.
13) 29 individuals seeking permanency resources statewide will be provided information and referral services.
14) 13 individuals who have adopted internationally who are seeking permanency resources statewide will be provided information and referral services.
15) 10 individuals within the permanency community will be fostered in leadership development to support the development of a statewide organization for adoptive parents, legal guardians, and permanent custodians on Oahu.
16) 40 Permanency support groups with child care (alone or in conjunction with other organizations) on Oahu will be provided.
17) 2 international adoptive families will attend support groups on Oahu.

Tracking ongoing services is an integral part of the quality assurance system for the PSS program. Accurate tracking acts as an ongoing needs assessment of the clients being served. Training for staff and supports to clients can be modified to ensure the most up-to-date information is available. In order to track accurately, all service data is recorded over time for each client utilizing a client spreadsheet. A quarterly worksheet is also utilized for tracking purposes. The tracking data is reviewed during supervision and worksheets are reviewed quarterly by the Program Administrator and consolidated for inclusion in the quarterly report. All service activity information will be reported quarterly.

Outcomes

1) 95% of families will have no confirmed reports of child maltreatment during program services.
2) 95% of families will have no placement disruptions during program services.
3) 80% of families receiving intensive in-home services will demonstrate progress towards their treatment goals.
4) 80% of children will demonstrate improvement in the attainment of their developmental milestones.
5) 100% of adoptive parents, legal guardians, and/or permanent custodians seeking information and/or referrals to permanency resources will receive assistance.
6) 80% of adoptive parents, legal guardians, and/or permanent custodians will report satisfaction with seminars, workshops, and trainings.
7) 80% of service providers will report satisfaction with seminars, workshops, and trainings.

Outcome data provides information to understand the effectiveness of the Program. For example, it speaks to whether or not the Program is meeting programmatic goals for each client. This information is tracked in a client database as well as aggregated in quarterly reports and various service/client worksheets. The information is reviewed as part of the organization's PQI process and trend data and recommended responses are made to ensure the highest quality of program services possible.

III. FINANCIAL

Budget

1. The applicant shall submit a budget utilizing the enclosed budget forms as applicable, to detail the cost of the request.

See attached budget forms.

2. *The applicant shall provide its anticipated quarterly funding requests for the fiscal year 2012-2013.*

Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Grant
$40,097.25	$40,097.25	$40,097.25	$40,097.25	$160,389.00

3. *The applicant shall provide a listing of all other sources of funding that they are trying to obtain for fiscal year 2012-2013.*

Not applicable.

4. *The applicant shall provide a listing of all state and federal tax credits that have been granted within the prior three years. Additionally, the applicant shall provide a listing of all state and federal tax credits they have applied for or anticipate applying for pertaining to any capital project, if applicable.*

   Not applicable.

IV. EXPERIENCE AND CAPABILITY

A. Necessary Skills and Experience

All of the PSS staff meet or exceed the educational qualifications of this proposal. Staff are also provided the necessary training to equip them in providing the services described. All services are provided by qualified staff. Staff required to have a Master's or Bachelor's Degree either have this degree in social work or have a degree in sociology, psychology, or human development with at least one (1) year experience dealing with child abuse and neglect.

The PSS Program has the skills, abilities and knowledge to successfully provide the services described in this proposal. All of the current direct service staff in the PSS Program are skilled in providing services in the child welfare arena. They have learned how to successfully engage and retain at-risk families in home visiting services. They also skilled in utilizing program model protocols, procedures, timelines and tools to identify, assess, strategize, address, and monitor risk status of referred families. They build and maintain trusting relationships with at-risk families, and have the resources necessary to ensure that these families receive appropriate medical and social services.

Because CFS staff has become skilled at supporting families through deeper grief/loss work, the program has been able to offer a variety of activities and group support. For example, the program began assisting a family whose legal guardian was dying from terminal cancer. The PSS team was able to transition the teenage sisters to spend more time with the adult sibling who may possibility take guardianship and to work closely with this family with positive open communication. This open and ongoing case requires a skilled Social Worker/Therapist to be there for support and counseling. Services have been greatly enhanced to this family as the team focuses on their unique individual skills to meet their needs as well as the collective team efforts needed to support them in this challenging transition.

Management staff in the PSS Program have skills in advocacy and are able to help meet the needs of the programs they oversee. They have specialized training and skills in the domestic violence field, mental health, and child welfare. They are able to support the staff in their day-to-day work with families. The PSS Program has been able to complete all the required reports in a timely, professional, and accurate manner. Their clinical skills and supervisory/administrative skills provide them with insight at both a macro and micro level in regards to program, client, and employee issues. Skilled in crisis

intervention, the management staff members have calm demeanors that are helpful during crisis situations.

PSS staff has also developed skills in responding to crisis situations over the phone. The program has a phone line to provide information on adoptions, legal guardianship, and questions regarding permanency. PSS staff answer questions from families, professionals and others interested in adoption or legal guardianship. Staff are skilled in supporting the callers if in crisis, providing information and referring to other services when appropriate.

Paraprofessional staff either have a High School Diploma or G.E.D. and a minimum of 1 year
PSS staff have experience and are trained in the area of child development, domestic violence, child abuse and neglect, substance abuse and permanency issues. All staff will understand and are willing to work with families with children who present with safety issues. A list of required trainings are described in this proposal.

Staff who conduct assessments, develop IPPs, provide child related skills building and parental life skills/support have a Bachelor's Degree from an accredited institution or equivalent training and experience approved by the Department of Human Services.

Only staff with a Master's Degree in social work or related field from an accredited university provide counseling and clinical therapy. These same individuals have had experience and training in working with families who have harmed or threatened to harm their children.

Staff with a Master's Degrees or equivalent experience (which has been approved by the Department) provide supervision for the program. These individuals have had relevant training and experience in working with families who have harmed or threatened to harm their children. Supervision and training is detailed throughout the proposal.

For those staff who have a High School Diploma, hands on training in problem solving, parenting, coordination of activities, service linkage will be provided. More details on training can be found throughout the proposal.

Child & Family Service has extensive experience in the Field of Child Abuse and Neglect on a statewide basis. CFS has taken an active role in the prevention, intervention and treatment of child abuse and neglect. Working with the Department of Human Services to increase the safety of children is a major commitment that CFS takes very seriously. As early as the 1940's, CFS provided advocacy for legislative change and counseling to families and children impacted by child abuse/neglect. CFS has implemented programs throughout the State in collaboration with DHS to provide quality services to the families and children impacted by child abuse/neglect. Examples include Home-based Services in 1989, Family Reunification Support Services in 1993, Outreach and Visitation Services in 1997, Family Support Services in the 1980's, and Group Family Treatment in the 1990's. In 1999, these above services were combined into the current Comprehensive Counseling and Support Services which integrate the components of home-based counseling, parenting, and visitation to lead to a safe permanent plan for a child within

one year. Diversion Services, now Family Strengthening Services began in 1996 and CFS piloted the first program on Oahu. Sex Abuse Treatment Services began in 1986 and the Community Centers were developed on Kauai in 1996 and 2001. In 2005, CFS began the Enhanced Healthy Start Program similar to the Healthy Start model but geared toward families referred by DHS. Voluntary Case Management was added to the service array in 2006.

CFS has been an active partner with the Department of Human Services in providing these services and implementing new models of care as the needs of families change. Over time, CFS has developed the most comprehensive array of services for child abuse/neglect in the State. Services today include:

- Family Strengthening Services - Oahu, Hilo and Kauai
- Comprehensive Counseling and Support Services - Oahu, Maui and Kauai
- Voluntary Case Management - Maui and Kauai
- Sex Abuse Treatment Services - Oahu, Maui, Hilo and Kona
- Independent Living Program – Kauai
- Family / Community Centers – Kauai
- Enhanced Healthy Start – Oahu and Kauai

CFS has decades of experience providing prevention of child abuse and neglect. CFS has provided Healthy Start services since the 1980s. For many years, Healthy Start was a voluntary home visiting program that provided voluntary support services to families of children newborn to three years old. Healthy Start provided developmental screening, psychosocial assessment of the family and motivational readiness for treatment and counseling for issues such as domestic violence or substance abuse. In the last several years, the Healthy Start program funding has reduced significantly statewide due to the State's financial crisis. CFS continues to provide a program in one geographic area – Leeward. This site is one of the two remaining Healthy Start programs in the State.

CFS has gained enormous experience in this program in the areas of providing outreach, engaging resistant families, identifying strengths and challenges, providing child development screening and information, making referrals to other community resources and promoting parent child bonding. CFS also has a fifteen year history in providing HomeReach Services which are prevention services for families with children of all ages. Families are referred by the Parent Line and are provided support on parenting skills, education on child development, and linkage to community referrals. This vast experience in child abuse and neglect and home visiting contributes to CFS' strength as a solid provider of child abuse and neglect services.

In addition to its long history of providing services for child abuse and neglect, CFS has experience and expertise in critical areas such as domestic violence and mental health. Many families at-risk of child abuse and neglect have difficulties in these areas. CFS has been involved in advocacy, prevention and intervention of domestic violence since 1971. Domestic abuse shelters, batterer intervention programs, victim support services and domestic violence advocacy services for TANF eligible individuals. CFS also provides

clinical services to families and children impacted by emotional and behavioral difficulties. CFS administers residential programs in this area and serves high end clients who have DSM IV-R diagnoses. CFS staff members from both the domestic violence and mental health programs are accessible for consultation and training for those staff members working in child abuse and neglect programs. CFS also has numerous staff members who have worked in various programs throughout the organization. The child abuse and neglect programs have several staff members who have worked in other areas such as domestic violence and mental health. This cross fertilization of knowledge and training strengthens all staff members at CFS and better equips them to provide quality services.

In addition to its service delivery experience, CFS offers years of promoting a learning culture for its staff, working collaboratively in the community with numerous partners and agencies, developing in depth knowledge of the communities it serves, and strengthening its strong commitment to quality.

The Permanency Support Services Program has 11 years of experience in permanency services. CFS has assembled a highly qualified team with the experience needed to deliver quality PSS services and to maintain the viability of services at high standards. The PSS Program consists of staff members that have a combined employment history/experience with CFS of over 50 years. They represent a wealth of knowledge and skills in delivering service in permanency issues. All staff members currently exceed the minimum requirements for their position(s). Each staff person brings a wealth of knowledge and experience that directly relates to permanency services which translates to providing quality services.

Projects and Contracts Pertinent to the Proposed Services

CFS' extensive experience in child welfare over the past 70 years has helped to develop extensive experience and skills in working with children and families, all of which supports our ongoing ability to provide PSS services. Following is a comprehensive list of verifiable experience with projects and contracts pertinent to the proposed services. Those services provided on Oahu are highlighted:

Title of Service/Brief Description of Service	Contracting Agency, Contact Person, Phone Number, Email Address, and Mailing Address	Contract/Project Identification Number	Service Period	Performance Outcomes
Specialized Substance Abuse Treatment Services for Pregnant & Parenting Women & Children E Ala Hou provides specialized substance abuse treatment services for pregnant and parenting women and children.	Department of Health Alcohol and Drug Abuse Division Terri Nakano (808) 692-7511 terri.nakano@doh.hawaii.gov Kakuhihewa Building 601 Kamokila Blvd., Room 360 Kapolei, HI 96707	ASO Log No. 10-086	7/1/2009-6/30/2011	• 18% of women enrolled have completed treatment. (Target: 75%) • 100% of pregnant women receiving services have continuous prenatal services (at least 6). (Target: 50%) • 100% of women enrolled have received case management services and are referred or linked to appropriate services. (Target: 100%)
Baby S.A.F.E. – A Specialized Substance Abuse Outreach and Early Intervention Service for Pregnant Women on Kauai Provides substance using pregnant and parenting women with outreach, support case management, referrals to community resources, and drug and alcohol screening.	Department of Health Alcohol and Drug Abuse Division Terri Nakano (808) 692-7511 terri.nakano@doh.hawaii.gov Kakuhihewa Building 601 Kamokila Blvd., Room 360 Kapolei, HI 96707	ASO Log No. 04-038	7/1/2003-6/30/2009	• 74% of clients reduced their use of alcohol or other substances or remained abstinent during their pregnancy and after. (Target: 80%) • 36% of clients participated in substance abuse treatment. (Target: 80%) • 57% of clients participated in early prenatal care. (Target: 80%) • 86% of newborns were born into a substance free environment. (Target: 80%)
Independent Living Services for Youth Program Provides individual and group counseling to youth, ages 12-21 who are living in out-of-home-care on Kauai. The program provides learning opportunities to develop the skills needed to manage the transition to a productive and self-sufficient adult life.	Department of Human Services Clayton Higa (808) 586-5697 chiga@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	DHS-04-POS-1843	7/1/2003-6/30/2011	• 100% of youths' emotions/mood have improved or remained unimpaired. (Target: 80%) • 100% of youth have reduced risk of alcohol/substance abuse or remain abstinent. (Target: 80%) • 97% of youth have demonstrated increased independent living. (Target: 75%)
Permanency Support Services Provides adoptive, legal guardian and permanent custody families with supportive, therapeutic, prevention, and intervention service, which includes home based intervention, parent education, skill based workshops, counseling, therapy and advocacy.	Department of Human Services Clayton Higa (808) 586-5697 chiga@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	Oahu DHS-04-POS-1884 Kauai DHS-04-POS-1884	7/1/2003-6/30/2011 7/1/2003-6/30/2009	• 100% of clients have learned new parenting strategies such as becoming more skilled at setting limits with their child(ren). (Target: 75%) • 100% of clients are more skilled at setting limits with their child(ren). (Target 75%) • 100% of clients are more satisfied with their child-parent interactions. (Target: 75%)

Title of Service/Brief Description of Service	Contracting Agency, Contact Person, Phone Number, Email Address, and Mailing Address	Contract/Project Identification Number	Service Period	Performance Outcomes
Comprehensive Counseling and Support Services and Voluntary Case Management Provides a broad array of services to meet the needs of children and their families including: counseling, outreach services, parenting education classes, supervised visitation and voluntary case management for families referred by the Department of Human Services.	Department of Human Services Rachel Thorburn (808) 586-5245 rthorburn@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	Maui DHS-04-POS-1855 Kauai DHS-04-POS-1855	7/1/2003-6/30/2011 7/1/2009-6/30/2011	• 85% of families have shown improvement in their ability to problem solve including meeting the needs of their child(ren). (Target: 80%) • 90% of families with children under age 5 have not generated any substantiated report of harm/threatened harm while participating in the program. (Target: 90%) • 92% of families have shown improvement in their ability to protect their children and not generate reports of harm/threatened harm while participating in the program. (Target 80%)
Comprehensive Counseling and Support Services Provides a broad array of services to meet the needs of children and their families including: counseling, outreach services, parenting education classes, and supervised visitation for families referred by the Department of Human Services.	Catholic Charities Darlene Beatty (808) 524-4673 beattyd@catholiccharitieshawaii.org Clarence T.C. Ching Campus 1822 Keeaumoku Street Honolulu, HI 96822	Oahu DHS-04-POS-1889	7/1/2003-6/30/2011	Same as above.
Family Strengthening Services Provides short term outreach services to enhance coping, parenting skills, and prevent or reduce family stress to families that are referred by the Department of Human Services, Child Welfare Services (CWS) who are not active with CWS.	Department of Human Services Rachel Thorburn (808) 586-5245 rthorburn@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	Hilo DHS-04-POS-1845 Kauai DHS-04-POS-1846 Oahu DHS-04-POS-1848	7/1/2003-6/30/2011 7/1/2003-6/30/2011 7/1/2003-6/30/2010	• 98% of families have not generated any substantiated report of harm/threatened harm while participating in the program. (Target: 90%) • 97% of families have shown improvement in their ability to maintain the safety of the home. (Target: 80%)

Title of Service/Brief Description of Service	Contracting Agency, Contact Person, Phone Number, Email Address, and Mailing Address	Contract/Project Identification Number	Service Period	Performance Outcomes
Healthy Start Home Visiting Serves families with children prenatal to five years of age, with emphasis on children prenatal to three years of age, who have been assessed at-risk for child abuse and neglect.	Department of Health Maternal and Child Health Division Cindy Hirai (808) 733-9042 Cindy.Hirai@fhsd.health.state.hi.us 741-A Sunset Avenue, Room 204 Honolulu, HI 96816	Waianae DOH 94-02 Central DOH 96-085 Central and Waianae ASO Log # 02-071 Leeward ASO Log # 04-153 Kauai – including EID ASO Log #06-118	7/1/1988-8/15/2009 7/1/1989-8/15/2009 7/1/2003-8/15/2009 7/1/1989-6/30/2011 7/1/1989-8/15/2009	• 98% of all the target children of families engaged in the Healthy Start services achieved age-appropriate developmental milestones or are in process of referral for remedial service. (Target: 90%) • 99% of participating families maintained a safe living environment for their child/children. (Target: 95%)
Enhanced Healthy Start Serves families with children prenatal to five years of age, with emphasis on children prenatal to three years of age, who have been referred to Child Welfare Services.	Department of Human Services Rex Shilo (808) 587-3168 rshilo@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	Oahu DHS-06-POS-3129 Kauai DHS-06-POS-3130	7/1/2005-6/30/2011 7/1/2005-6/30/2011	• 100% of all the target children of families engaged in Healthy Start services achieved age-appropriate developmental milestones or are in process of referral for remedial service. (Target: 90%) • 98% of participant families have no new confirmed report of child abuse. (Target: 95%)
Head Start Provides comprehensive services to low-income and age eligible children including pre-school education, health program, empowering families to be self-sufficient, and programming for children with severe special needs.	U.S. Department of Health and Human Services Laura Candeloro (415) 437-8653 Laura.candeloro@acf.hhs.gov 90 7th Street, 9th Floor San Francisco, CA 94103	09CH9054 Head Start Main Head Start Expansion	7/1/2000-6/30/2010 7/1/2010-6/30/2011 10/1/2010-9/30/2011	• 83% of parents met their goal to assist their children with school readiness, such as reading, naming colors, etc. (Target 80%) • 98% of families have a designated medical home. (Target: 95%) • 98% of special needs children were referred and received services. (Target 90%)
Family Center Services Title IVB/2 Nana's House and Hale Ho`omalu offer family support centers with the primary goal of increasing availability and accessibility of services to reduce family violence, and child abuse and neglect.	Department of Human Services Clayton Higa (808) 586-5697 chiga@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	DHS-98-DDS-6326 Nana's House Hale Ho`omalu	7/1/1996-6/30/2011 7/1/2002-6/30/2011	• 100% of client families have identified other resources outside the community center. (Target: 75%) • 100% of client families have reduced the risk for child abuse and neglect. (Target: 75%)

Title of Service/Brief Description of Service	Contracting Agency, Contact Person, Phone Number, Email Address, and Mailing Address	Contract/Project Identification Number	Service Period	Performance Outcomes
Parenting Education and Support Through the Parent Line and Home Reach Provides phone support on parenting education, referrals and support services and a home visiting model to families of young children.	Department of Health Maternal & Child Health Branch Lyn Niitani (808) 733-4054 Lyn.Niitani@fhsd.health.state.hi.us 741-A Sunset Avenue, Room 204 Honolulu, HI 96816	Statewide ASO Log No.10-128	1/1/2010-6/30/2012	• 100% of parents calling the Parent Line received information on child development relative to their age of their child. (Target: 80%) • 100% of families served through Home Reach promoted nurturing and facilitated emotional attachments with their children. (Target: 90%) • 100% of parent educational resources were updated and distributed throughout that included concrete information regarding parenting. (Target: 100%)
Domestic Abuse Shelters and Support Services Offers four domestic violence shelters and 24-hour crisis hotlines for victims of domestic violence and their children in Leeward Oahu, Honolulu, West Hawaii and East Hawaii.	Department of Human Services Clayton Higa (808) 586-5697 chiga@dhs.hawaii.gov 810 Richards Street, Suite 400 Honolulu, HI 96813	Oahu DHS-11-POS-415 DHS-04-POS-1850 Hilo DHS-11-POS-416 DHS-04-POS-1900 Kona DHS-11-POS-417 DHS-04-POS-1844	 10/1/2010-6/30/2012 7/1/2003-9/30/2010 10/1/2010-6/30/2012 7/1/2003-9/30/2010 10/1/2010-6/30/2012 7/1/2003-9/30/2010	**Oahu** • 81% of clients have an increased knowledge of community resources. (Target: 75%) • 69% of single adults and families have moved from the shelter to a non-abusive home environment. (Target 60%) • 96% of clients in shelter have completed a Safety Plan for themselves and their children. (Target: 90%) **Hilo** • 98% of clients have an increased knowledge of community resources. (Target: 75%) • 71% of single adults and families have moved from the shelter to a non-abusive home environment. (Target 60%) • 81% of clients in shelter have completed a Safety Plan for themselves and their children. (Target: 90%) **Kona** • 99% of clients have an increased knowledge of community resources. (Target: 75%) • 43% of single adults and families have moved from the shelter to a non-abusive home environment. (Target 60%) • 98% of clients in shelter have completed a Safety Plan for themselves and their children. (Target: 90%)

B. Facilities

Child & Family Service is Accessible Statewide

CFS maintains facilities throughout the State which are equipped and appropriately furnished to deliver the full range of services.

Headquarters: The corporate office is located at 91-1841 Fort Weaver Road, Ewa Beach, Hawaii. CFS maintains 35 sites throughout the State, on the islands of Hawaii, Kauai, Maui, Molokai, and Oahu.

ADA Accessibility: CFS sites meet accessibility requirements of the Americans with Disabilities Act (ADA).

Communication Accessibility: CFS maintains a Wide Area Network (WAN) to provide data, resource sharing and connectivity between its' seven main offices and 27 satellite offices on five islands using frame relay technology. Home based and mobile staff are connected either through remote access (RAS) or web-based access (OWA). Staff members are issued desktop or laptop computers equipped with current, up to date technology. The application systems available to staff include a full suite of productivity tools, enterprise email, a windows-based accounting system, an applicant tracking system, a statewide correspondence tracking and records management system, a human resources/personnel system, a time and attendance system, and a client tracking system.

The organization is well equipped and resources are shared throughout. Resources include:

- Video monitors, DVD players and VCRs for showing educational tapes.
- Portable audio and video/DVD recorders for use in clients' homes for the purpose of showing educational material and to record family interactions for playback to clients. This helps them observe their interpersonal behavioral patterns.
- An extensive library of print and electronic material covering topics such as parenting skills, self-esteem, family systems, and family preservation.
- Videoconferencing capability is available at the Vineyard and Ewa sites on Oahu and at each neighbor island office. This facilitates communication between sites and creates more opportunities for training.

The Permanency Support Services Program Facility

The PSS Program is primarily an outreach and home visiting program. On occasion, a family may want to meet in an office setting or another location where they are comfortable. The Program remains flexible and strives to accommodate family preferences. Some services are office based such as groups. Although the program is primarily outreach, direct service staff members are required to report to the office frequently for staff meetings, training, supervision, and case record maintenance. Both

facilities provide individual counseling rooms as well as large meeting rooms for support groups or group training.

The Permanency Support Services Program office has two locations one office at the main Ewa campus and one office at 200 North Vineyard Boulevard, Building B, in downtown Honolulu, and will continue to remain at its current facilities with proper equipment and appropriate furnishings to deliver the full range of services. The two locations conveniently accommodate all of the program families on Oahu.

The PSS Program staff members currently occupy one office on both campuses and have access to three meeting rooms at Vineyard that can hold 10 to 40 people for orientation meetings, support groups and group trainings and three meeting rooms in Ewa that can hold 10 to 75 people for the same purposes.

The Permanency Support Services Program's current facility meets accessibility requirements of the Americans with Disabilities Act (ADA). The external and internal location of both the Vineyard and Ewa office is located on the first floor of the building, which is free from obstruction and stairs. The main building is accessible from the street to the servicing office and does not require the use of an elevator. The office is accessible inside and around the facility, including the restrooms, which are ADA compliant. Therefore, no special equipment or accommodations are required.

V. PERSONNEL: PROJECT ORGANIZATION AND STAFFING

A. Proposed Staffing, Staff Qualifications, Supervision and Training

At CFS there are different types and levels of clinical staff. Depending on the degree and years of experience their job title is either Social Worker or Therapist. All of these positions require a Master's Degree from an accredited university and differing amounts of experience. For sake of clarity, positions will be referred to in this document as "Social Worker/Therapist." The Bachelor's level position is the Child Development Specialist. The Family Service Worker position requires a minimum of a high school diploma or equivalency.

The program is sufficiently staffed to maintain the viability of the proposed program as well as the administrative infrastructure needed to support timely delivery of services. One part-time Social Worker/Therapist and one full-time Child Development Specialist, and two part-time Family Service Workers who will serve the 50 families required annually by carrying an increased number of cases from the first month of the contract through the third month when families will begin to be discharged from the program. Assuming that approximately 7 families per month will be referred for services, and that services are normally provided for a period of 3 months, the case load will vary from 7 families to 42 families at any given time.

The Social Worker/Therapist and the Child Development Specialist work together with most of the families. The Social Worker/Therapist provides the more intensive clinical

interventions while the Child Development Specialist teaches skill building and provides information on child development. The Family Service Worker also assists with some of the hands on teaching. In the event of illness, vacation, vacancies, or other situations that would result in a lower number of families served, the Social Worker/Therapist and Child Development Specialist will provide coverage for each other with the Program Administrator assisting as needed and covering for the master's level duties. Other permanency information and referral projects offered by the program including the permanency website, the permanency resource library, the phone line directory of agencies, professional services, training, and other resources will be managed by all staff. The Web Master/Communications Coordinator position will take the lead for the directory and the permanency website but the 5 hour a week position will require the support of the secretary and others.

In the event an interpreter is needed, the program will work on allocating resources to provide services which may include a budget revision. CFS currently has an independent contract with the Bilingual Access Line (BAL) through Helping Hands Hawaii and Pacific Gateway Center. BAL has been providing services since 1985. All applicants are screened for language ability before hiring. They must have a minimum of two years experience in medical and/or legal terminology; fluency in the English Language and a second language. They must pass a screening exam that measures language ability, vocabulary, written translation, listening comprehension and interpreting skills. They cover 17 primary languages and also provide referrals for 90 secondary languages. Pacific Gateway has been providing services since 1973, the center has worked off a model that gives struggling individuals access to resources to fulfill basic needs such as emergency food and rent money, and translation and immigrant services. They offer a wide range of language interpreters and all adhere to CFS policies and procedures.

Proposed Staffing

The program staff have appropriate qualifications and necessary training to provide the proposed services and activities and demonstrate knowledge, capacity, skills and experience in working with the target population. The program staff are also knowledgeable of positive youth development philosophy and strategies. The proposed service team is outlined below.

Position	Full Time Equivalency (FTE)	Program Specific Responsibility
Director of Program Services	0.03 FTE	Primary oversight responsibility for services and statewide programs. Provides supervision and consultation to the Program Administrators/Directors.
Clinical Coordinator	0.03 FTE	Assists in the planning and implementation of the organization's accreditation activities and assists the program staff in quality improvement and implementing program contract requirements.

Position	Full Time Equivalency (FTE)	Program Specific Responsibility
Program Administrator	0.19 FTE	Primary oversight responsibility for the direction of the program.
Social Worker/Therapist	0.20 FTE	Provides clinical counseling for families, conducts intake and assessment including review of referral information, identifying and engaging key caregiver, and develops IPPs based on the assessment with measurable objectives. Plans are reviewed at specified intervals with the client(s), and amended as needed to meet client and program goal. Provides treatment or service interventions following the treatment/service plan, using program compatible interventions based on best practice research.
Child Development Specialist	1.00 FTE	Provides parent education, training, and modeling of developmental activities to enhance and promote healthy development. Monitors attachment and development. Assists in community linkages. Conducts developmental assessments. Makes referrals to service providers as indicated. Assures that a safe environment is maintained. Provides information to parents regarding child development issues and intervention. Provides home-based education regarding parenting skill. Models effective child-parent interaction, especially in the areas of social/emotional, language, and cognitive development. Monitors child development using standardized tools and health status. Makes referrals for needed services, including but not limited to health care, education, social services and mental health services. Provides case coordination and case management. Provides services indicated on IPPs. Provides individualized activity/intervention strategies in cooperation with parent and other service providers.
Family Service Worker (two part-time)	1.30 FTE	Assists families with referrals and linkages to community resources and ensures proper consent forms are completed by clients. Can assist in providing transportation to medical, legal, and social service appointments as needed and after

Position	Full Time Equivalency (FTE)	Program Specific Responsibility
		consultation with supervisor. Supports program and collaborative groups with child care. Able to support families with respite after consultation with supervisor and treatment team.
Web Master / Communications Coordinator	0.01 FTE	Maintains the website, respond to inquiries and messages, and makes appropriate referrals. The website will be updated regularly and post new information on workshops and events, orientation and training schedules, contact information for support groups, permanency support services workshops and other permanency resources.
Program Secretary	0.158 FTE	Provides clerical support to the program.

Staff Qualifications

The following chart shows the position minimum qualifications of staff positions for this proposal. As described above, current staff in the PSS Program meet or exceed qualifications.

Position	Qualifications
Director of Program Services	Master's Degree in Human Services and six years post Master's experience in supervision and administration with strong leadership skills.
Clinical Coordinator	Master's Degree in Human Services from an accredited school. One year supervisory experience required. Knowledge of and experience with quality improvement activities required.
Program Administrator	Master's Degree in Human Services and four years post Master's supervisory and administration experience in community or social services settings. Experience in working with families with children who have been or are threatened with harm is strongly preferred.
Social Worker/Therapist	Master's Degree in social work or a related field from an accredited institution and a minimum of one-year experience with domestic violence, substance abuse, permanency issues, and child abuse and neglect with families with children who have been or are threatened with harm strongly preferred.
Child Development Specialist	Four year college degree from an accredited school in early childhood or related field. Two years experience in child development is preferred. Experience with domestic violence, substance abuse, permanency issues, and child abuse and neglect is required. Experience in working with families with children who have been or are threatened with harm is strongly preferred.

Position	Qualifications
Family Service Worker	High school and six months of experience working with children, and knowledge of child development. Experience working with children who have experienced trauma/abuse is preferred. Experience in working with families with children who have been or are threatened with harm is strongly preferred.
Web Master / Communications Coordinator	High school plus additional courses or specialized training at business or community college, or other formal training facility or program.
Program Secretary	High school and business training. Able to use computer with one to two years experience.

Criminal history background checks: Once an employment offer is tendered and accepted, a criminal history check is conducted via the Hawaii Criminal Justice Data Center for all new direct service employees. A printed report of each criminal conviction record check is maintained in the employee's personnel record. An offer of employment is withdrawn or the position of a direct service provider is terminated when a prospective or current direct service provider has a criminal conviction as indicated as follows:

- The criminal conviction occurred within the last 10 years; and
- The crime for which there is a conviction has a rational relationship to a direct service provider's position.

CPS Registry checks: Once an employment offer is tendered and accepted, a check is conducted via the Protective Services Central Registry for all new direct service employees. A printed report of each record check is maintained in the employee's personnel record. A check is completed upon initial hire, twelve months later, and thereafter, every two years.

Unfavorable findings do not necessarily result in the employee's dismissal and are reviewed on a case-by-case basis with the following criteria:

- The nature and gravity of the offense
- The amount of time that has passed since the offense
- The nature of the position in question

Driver's Abstract: Once an employment offer is tendered and accepted, a Driver's Abstract is requested from the new hire who is required to drive, as determined by their job description. A check is completed upon initial hire and annually upon anniversary date. The document obtained by the employee is maintained in the employee's personnel record. Employees are required to have a satisfactory Driver's Abstract. Satisfactory is described as:

- No more than one moving violation in the past three years, and
- No DUI convictions within the past three years.

Supervision

CFS has well established procedures and expectations for supervision. The process of supervision holds individual staff accountable for appropriate performance of their assigned duties and responsibilities, ensures the quality of client services, and provides a mechanism for professional development. One of the major goals of the supervisory process is to provide direct line staff with the knowledge and support to remove barriers to accessing services and achieving outcomes with their cases.

The supervisory ratios do not exceed one direct service supervisor to seven full-time direct service staff. The supervisor determines how frequently supervision sessions need to occur based on accreditation and contract standards. The immediate supervisor is responsible for ongoing supervision of staff.

Supervisory sessions may be individual sessions or group sessions as defined by contract, accreditation standards and/or professional practice. All supervisory sessions are documented in an individual supervisory file, maintained by the supervisor. The supervision notes document the session dates, issues discussed, and related action plans. During the supervisory session, the supervisor reviews case record documentation to ensure that the documentation:

- Complies with the organization and program policies and procedures.
- Reflects implementation of direct practice principles within the scope of the program philosophy and/or method of service/treatment.

CFS provides client-centered supervision which enhances the quality of client services and provides a mechanism for professional development. Client-centered supervision occurs quarterly, at minimum, and includes the following:

- Evaluation of the client's progress toward achieving his/her service/treatment goals.
- Review of the appropriateness of the service/treatment plan.
- Review of case record documentation.

Accountability and Adherence to the Service Model and Performance Standards

Supervision procedures have been developed to maintain quality delivery of services and provide for systematic ongoing monitoring of staff. The Program Administrator will work to help the staff reach their potential and excel as professionals through their daily interactions with them. Team building activities enhance cohesiveness which contributes to both client and staff satisfaction.

Supervision is provided through one hour individual and/or group supervision which occurs twice a month. Group meetings allow program staff to collaborate together, discuss the overall status of the program, share concerns and provide input, review policies and procedures, case management issues, and community resources linkage. The Program Administrator and staff also discuss individual cases, program and personnel

issues such as training, resources, documentation and client chart reviews. General personnel issues like standards of conduct and schedule for holidays and/or vacations, reviewing of agency code of ethics or program training requirements are also reviewed at these meetings. Specific individual supervisory disciplinary concerns including timeliness or adherence to attendance rules are conducted in one on one sessions and action plans with follow-up dates are documented and created with staff.

Additional meetings are scheduled as needed between the supervisor and staff members. Individual and group supervision sessions use a strengths-based positive approach to support the staff. Regular follow-up is done to ensure the Program Administrator is providing the staff with the knowledge, skills, and tools they need to succeed. The Program Administrator's experience as a supervisor and extensive training in supervisory skills is evident in her ability to supervise and train her team. CFS is committed to supporting their success and assisting staff with challenges.

The staff members in the program have clearly defined roles. However, the program has a tremendous amount of flexibility in meeting the needs of the clients within the limits set by DHS. Even though each staff member has an area of focus, each one is able to step in and assist in a different area as needed. Staff members are cross trained to provide for the most thorough and efficient customer service in meeting the needs of the clients and their families.

The program has written position descriptions and procedures for recruitment, selection, and training for qualified staff that help build a dynamic and well-rounded team to work with children, individuals and families. Procedures for clear communication and lines of authority are established along with guidelines and clear statements of responsibility for job functioning. Job performance/evaluation reviews are conducted annually. The reviews specify areas of strength and needs for improvement for individual staff. Professional Development Plans for each staff keep commitments to growth and skills improvement among all staff from managers to direct service staff.

Training – Enhancing Skills and Knowledge

CFS is committed to increasing staff knowledge and skill development through its training program. In a recent survey, CFS employees identified the ability to learn and develop their skills as an important reason they work for CFS. The organization has invested considerable resources in training and the development of training modules, as well as videoconferencing capacity. This enables CFS staff on all islands to receive standardized information.

To promote excellence in supervision, CFS provides extensive supervisory training. New hires receive a supervisory orientation that includes organization overview and structure, staff management, financial management, program development, risk management, and a communication overview. Supervisors are provided with the procedures and tools for each of these processes. Within the first year of employment, supervisors attend advanced sessions in human resources, fiscal, and administration. In addition, CFS

requires supervisors to attend a clinical supervision training module. This module covers topics such as assessing staff strengths, defining supervisory styles, core components of supervision, and understanding the dynamics of change.

CFS has developed internal training modules for direct service staff and supervisors on Child Abuse and Neglect, Substance Abuse, Engaging Challenging Families, Positive Behavior Supports, and Medication Management. In addition to these training modules, the CFS Quality Assurance and Training Department developed PowerPoint trainings on Case Management, Client Advocacy, Reportable Criminal Behavior, Stress Management, Case Documentation, Maintaining Professional Boundaries, Therapeutic Rapport, Communication Barriers, Family Violence, Emergency Response Practice and Safety in the Field, and Community Based Practice – Psychosocial Approach. These trainings are available and accessible to all staff via a CFS shared computer drive.

CFS' Training Committee has established requirements for orientation and ongoing training at an organization wide level. These requirements include those topics that are mandated for the organization to meet accreditation standards. In addition, each program has identified specific requirements for orientation and training that meet contract requirements and accreditation standards. All CFS staff receive announcements of upcoming training opportunities, both internal and external, through the Quality Assurance and Training Department.

Orientation to the Program and the Organization

CFS provides orientation for both the program and the organization. The Permanency Support Services program will provide orientation to staff members within 30 days of employment with the organization. CFS requires all new hires to attend an organization wide orientation within 60 days of employment. The lists below highlight some of the topics covered in these orientations.

Program Specific Orientation – within 30 days of employment
• Review of job description
• Review of program training plans
• Program service hours and work schedule, phone contact list, emergency contact form
• Review of program and ethical standards
• Review of documentation requirements, including client-related forms, client files, service provision records, quarterly report data forms, and timelines for submission of reports
• Review of referral process and resources
• Review of administrative policies and procedures, confidentiality and HIPAA
• Review of program specific policies and procedures, COA and contract requirements
• Review of assessing risk and safety of persons served and mandated reporting
• Techniques for handling emergencies
• Orientation to the establishment of rapport and responsive behaviors
• Orientation of the collaboration with other disciplines and community services in meeting the needs of the persons served
• Review of appropriate coordination with mental health, law enforcement, and other professionals

Program Specific Orientation – within 30 days of employment
• Orientation of the basic health and medical needs of the service population
• Orientation on the needs of families in crisis, including needs of victims of violence, child abuse and neglect, and family members
• Orientation on the procedures for working with foreign language speakers and persons with communication impairments and the use of interpreters
• Orientation on public assistance programs
• Review of personal and client safety issues
• Review of supervision procedure and schedule, program and department staff meetings, and training plan
• Orientation on email, CFS network, g and y drives, timekeeping system, and databases

Organization Orientation – within 60 days of employment
• Mission, vision and values of CFS
• Organization structure and overview, including communication plan and strategic planning
• Performance and Quality Improvement process
• Safety program and purpose, including worker's compensation overview
• Information technology, including computer network access and usage
• Overview of behavior management policy, State and Federal laws on confidentiality including HIPAA
• Overview of philosophy of person and family centered services, cultural competency, client participation in planning and delivery of services, strengths based client assessment and services, collaboration with other agencies/partners
• Client rights and responsibilities, client grievances and complaints process and client satisfaction

By the end of the first quarter of employment, employees receive training in:

- Cultural competency/cultural approaches with various populations
- Personal safety and appropriate behavior management techniques
- Awareness of special needs populations
- HIPAA Policies and Procedures

Ongoing Training

Once an employee completes orientation, ongoing training opportunities are provided. An individualized training plan is developed between the supervisor and staff. The plan identifies areas that need further development. The supervisor tracks the staff development as an integral part of regular supervision.

Training topics for ongoing training include but are not limited to:

Training Focus	Trainings
Program Philosophy	• DHS Guiding Principles • Protective Factors for families • Child Abuse and Neglect dynamics, prevention and intervention strategies
Risk, Legal and Regulatory Requirements	• Mandatory reporting • DHS statutory mandates under 45 CFR 1340; Hawaii Revised Statutes 346, 350, and 587; and Hawaii Administrative Rules and Departmental procedures • Reportable criminal behavior • Review of risk management/ reporting standards • Behavior management (CFS policy and procedures) including nonviolent crisis intervention • CPR and First Aid
Assessment and Service Planning	• CFS Comprehensive Basic Assessment • Identifying family and individual strengths • Adolescent and Adult Parenting Inventory (AAPI-2) • Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire – Social Emotional (ASQ-SE)
Service Delivery Basics	• Documentation • Client advocacy • New referral resources in the community • Case management/collaboration/ coordination • Child development • Basic health and medical needs of the service population to include special needs • Service provision through home visiting and community-based settings • Working with clients with communication barriers
Clinical Knowledge and Skills	• Professionalism/boundaries • Mental health basics and common diagnoses • Building therapeutic rapport • Basic counseling skills • Needs of individual and families in crisis; to include suicide precautions • Substance use and abuse • Common challenges of children in adoptive care and interventions
Quality Assurance	• Program outcomes development and measurement • Integration, coordination and monitoring of service quality standards
Supervisory	• Tracking and Supervisory Tools • Supervisory training; administration, human resources, supervision and fiscal
Cultural Competency	• Values and beliefs of the various cultures in Hawaii

Additional training needs are determined through the quality improvement process, through information on Best Practice models or are identified by staff members and their supervisor during individual supervision. In order to be cost effective, CFS programs are able to utilize other programs within the organization for training on child development, domestic violence, mental health, and substance use and abuse.

Program staff members will be required to attend Ohana Conferencing training.

B. Organization Chart

All CFS programs are supported organizationally by management staff who oversee and monitor the quality and integrity of the community-based services.

The program is sufficiently staffed to maintain the viability of the proposed program as well as the administrative infrastructure needed to support timely delivery of services. One part-time Social Worker/Therapist and one full-time Child Development Specialist, and two part-time Family Service Workers who will serve the 50 families required annually by carrying an increased number of cases from the first month of the contract through the third month when families will begin to be discharged from the program.

CFS provides the infrastructure and support to manage programs effectively. This support is provided through a number of mechanisms including direct supervision and guidance from the Vice President of Programs, Director of Program Services, Quality Assurance and Training Department, strategic planning process, CFS communication plan, and senior management.

The statewide CFS organization chart is attached, which highlights where Permanency Support Services fits within the organizational structure and illustrates the reporting structure. The organizational chart for Permanency Support Services highlights positions and minimum qualifications.

VI. OTHER

A. Litigation

CFS is a party in the following lawsuit:

- Haldeman, et al. vs. University of Nations Pre-School; The University of Nations; Hawaii County Police Department; Child Protective Services; Department of Human Services; and CFS, Jointly and Severally

  Case No. CV05-00810 DAE KSC, filed in the United States District Court for the District of Hawaii.

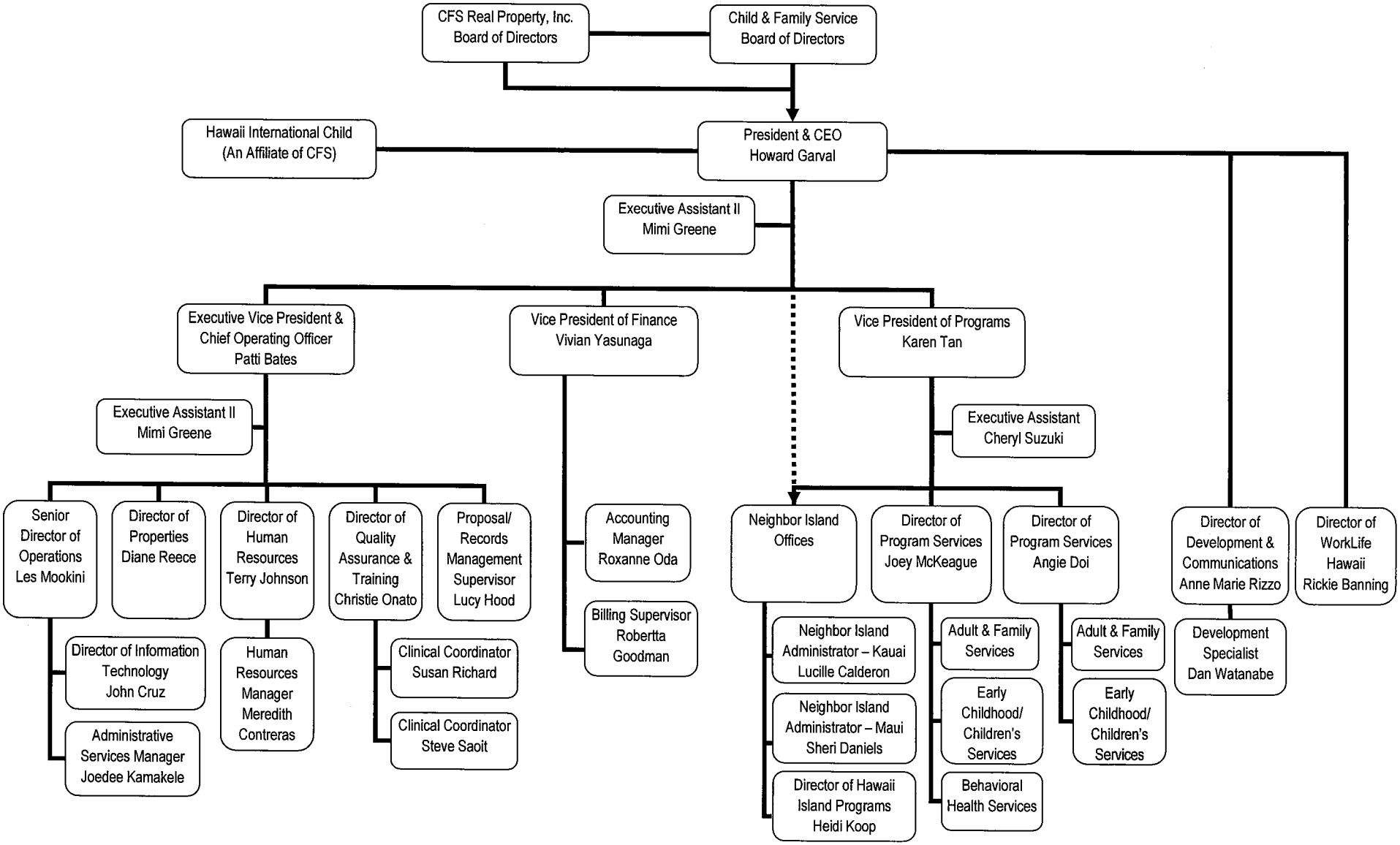
  CFS was named in a complaint filed on December 28, 2005 with CFS filing an answer on June 2, 2006. On April 29, 2008 the Federal District Court granted CFS

and Clark's Motion for Summary Judgment. Trial as to the remaining parties was stayed pending disposition of an appeal filed by the Karen Duty and Donald Cupp (State of Hawaii case workers) as to the Court's denial of their Motion for Summary Judgment. CFS is not a party to this appeal. The District Court denied Plaintiff's motion to enter final judgment on Plaintiffs' claims against CFS and other defendants who were dismissed upon motion for summary judgment. No trial date has been scheduled on the remaining claims.

B. Licensure or Accreditation

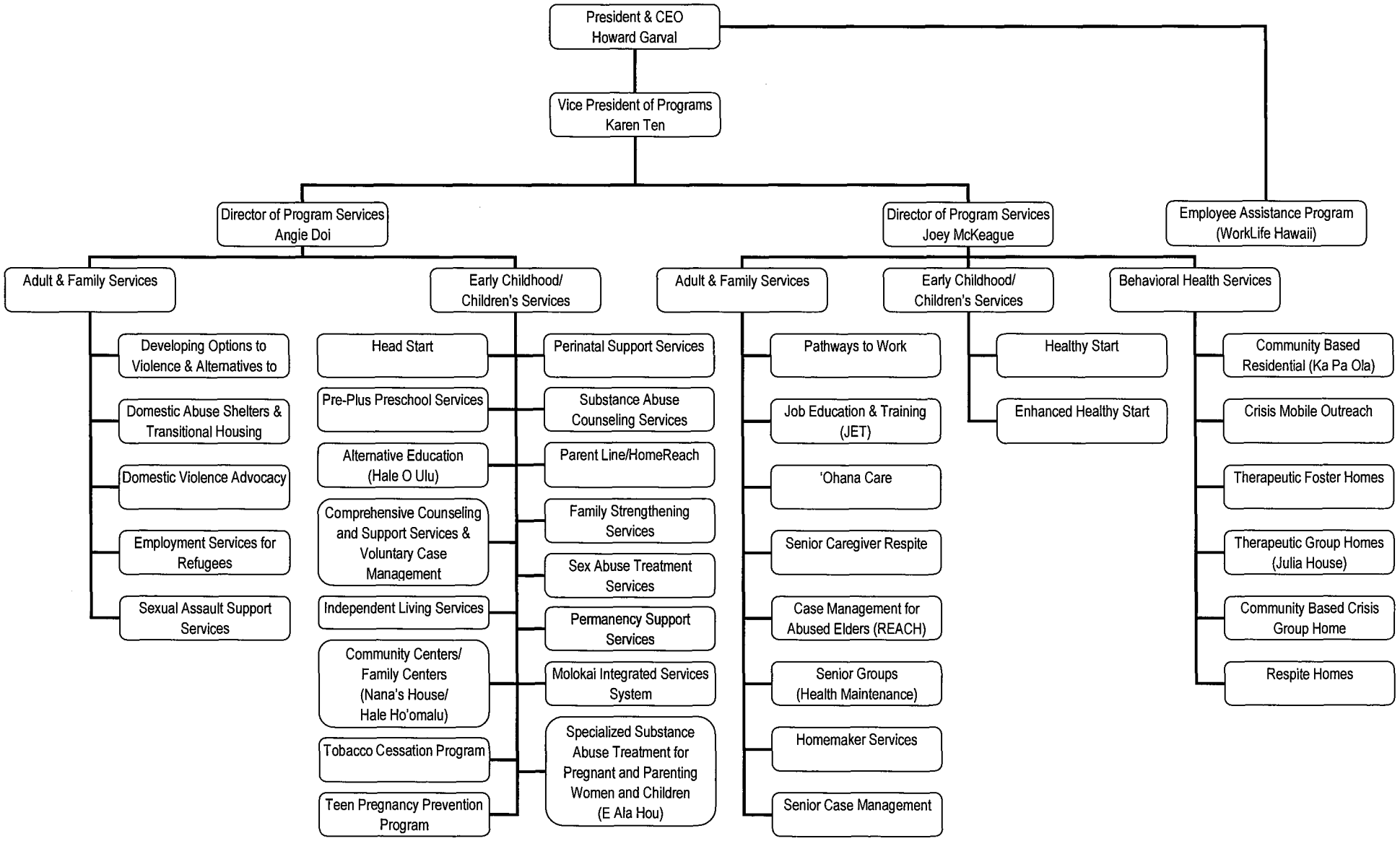
The Council on Accreditation (COA) has accredited CFS since 1980. As a member of COA, CFS maintains the highest standards in organization management and program delivery. CFS has also been a member of the Alliance for Children and Families since 1986. Because of its accreditation status and membership in national organizations, CFS has access to current research data and Best Practices models.

Child & Family Service
Organization Chart



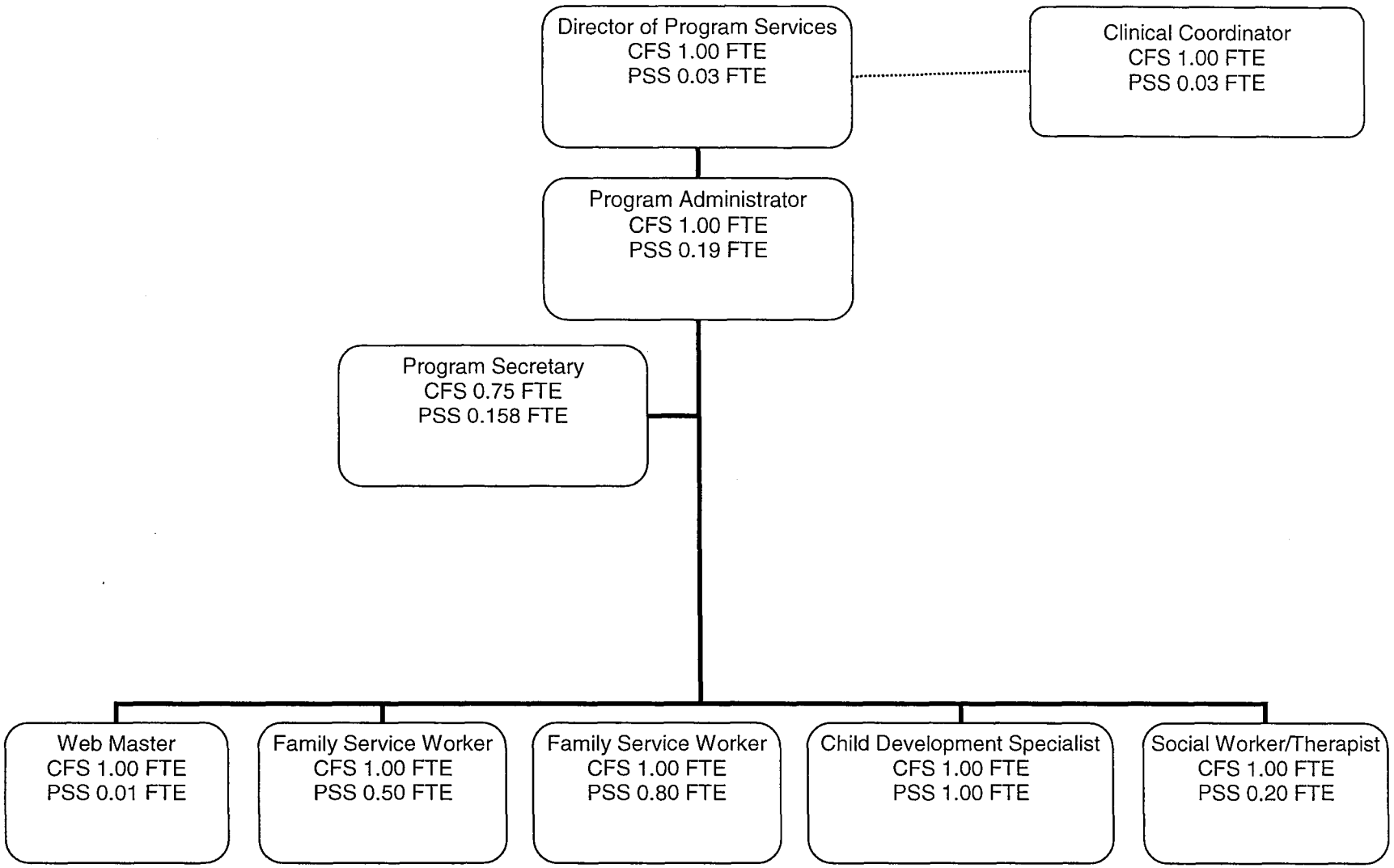
Updated 11/8/11 LH

Child & Family Service
Organization Chart



Updated 11/8/11 LH

Child & Family Service
Permanency Support Services - Oahu
Organization Chart



BUDGET REQUEST BY SOURCE OF FUNDS
(Period: July 1, 2012 to June 30, 2013)

Applicant: Child & Family Service- Permanency Support Services

BUDGET CATEGORIES	Total State Funds Requested (a)	(b)	(c)	(d)
A. PERSONNEL COST				
1. Salaries	92,449			
2. Payroll Taxes & Assessments	12,734			
3. Fringe Benefits	13,052			
TOTAL PERSONNEL COST	**118,235**			
B. OTHER CURRENT EXPENSES				
1. Audit Services	401			
2. Insurance	2,470			
3. Contractual Services - Subcontractors	200			
4. Lease/Rental of Equipment	1,362			
5. Lease/Rental of Space	7,114			
6. Mileage	3,500			
7. Postage Freight & Delivery	120			
8. Publication and Printing	180			
9. Repair & Maintenance	200			
10. Staff Training	200			
11. Supplies	918			
12. Telecommunication	1,835			
13. Other: Client Assistance	1,200			
14. Other: Administrative Support	22,454			
TOTAL OTHER CURRENT EXPENSES	**42,154**			
C. EQUIPMENT PURCHASES				
D. MOTOR VEHICLE PURCHASES				
E. CAPITAL				
TOTAL (A+B+C+D+E)	**160,389**			

SOURCES OF FUNDING		Budget Prepared By:	
(a) Total State Funds Requested	160,389	Rachel Desrochers, Budget Monitor II	808-681-1405
(b)		[redacted]	Phone
(c)			01/27/12
(d)			Date
TOTAL BUDGET	**160,389**		

BUDGET JUSTIFICATION
PERSONNEL - SALARIES AND WAGES

Applicant: Child & Family Service- Permanency Support Servic

Period: July 1, 2012 to June 30, 2013

POSITION TITLE	FULL TIME EQUIVALENT	ANNUAL SALARY A	% OF TIME ALLOCATED TO GRANT REQUEST B	TOTAL STATE FUNDS REQUESTED (A x B)
Director of Program Services	1	$78,030	3.00%	$ 2,341
Program Administrator	1	$65,664	19.00%	$ 12,476
Clinical Coordinator	1	$49,285	3.00%	$ 1,479
Program Secretary	1	$28,629	15.80%	$ 4,523
Child Development Specialist	1	$31,951	100.00%	$ 31,951
Social Worker/Therapist	1	$41,902	20.00%	$ 8,380
Family Service Worker	1	$23,762	50.00%	$ 11,881
Family Service Worker	1	$23,762	80.00%	$ 19,010
Web Master	1	$40,798	1.00%	$ 408
TOTAL:				$ 92,449

JUSTIFICATION/COMMENTS:

Salaries are based on a Market median study to maximize recruitment and retention.

BUDGET JUSTIFICATION - EQUIPMENT AND MOTOR VEHICLES

Applicant: Child & Family Service- Permanency Support Services

Period: July 1, 2012 to June 30, 2013

DESCRIPTION EQUIPMENT	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
			$ -	
			$ -	
			$ -	
			$ -	
			$ -	
TOTAL:				

JUSTIFICATION/COMMENTS:

N/A

DESCRIPTION OF MOTOR VEHICLE	NO. OF VEHICLES	COST PER VEHICLE	TOTAL COST	TOTAL BUDGETED
			$ -	
			$ -	
			$ -	
			$ -	
			$ -	
TOTAL:				

JUSTIFICATION/COMMENTS:

N/A

BUDGET JUSTIFICATION
CAPITAL PROJECT DETAILS

Applicant: Child & Family Service- Permanency Support Service

Period: July 1, 2012 to June 30, 2013

FUNDING AMOUNT REQUESTED						
TOTAL PROJECT COST	ALL SOURCES OF FUNDS RECEIVED IN PRIOR YEARS		STATE FUNDS REQUESTED	OF FUNDS REQUESTED	FUNDING REQUIRED IN SUCCEEDING YEARS	
	FY: 2010-2011	FY: 2011-2012	FY:2012-2013	FY:2012-2013	FY:2013-2014	FY:2014-2015
PLANS						
LAND ACQUISITION						
DESIGN						
CONSTRUCTION						
EQUIPMENT						
TOTAL:						
JUSTIFICATION/COMMENTS: N/A						

DECLARATION STATEMENT
APPLICANTS FOR GRANTS AND SUBSIDIES
CHAPTER 42F, HAWAI'I REVISED STATUTES

The undersigned authorized representative of the applicant acknowledges that said applicant meets and will comply with all of the following standards for the award of grants and subsidies pursuant to section 42F-103, Hawai'i Revised Statutes:

(1) Is licensed or accredited, in accordance with federal, state, or county statutes, rules, or ordinances, to conduct the activities or provide the services for which a grant or subsidy is awarded;

(2) Comply with all applicable federal and state laws prohibiting discrimination against any person on the basis of race, color, national origin, religion, creed, sex, age, sexual orientation, or disability;

(3) Agree not to use state funds for entertainment or lobbying activities; and

(4) Allow the state agency to which funds for the grant or subsidy were appropriated for expenditure, legislative committees and their staff, and the auditor full access to their records, reports, files, and other related documents and information for purposes of monitoring, measuring the effectiveness, and ensuring the proper expenditure of the grant or subsidy.

In addition, a grant or subsidy may be made to an organization only if the organization:

(1) Is incorporated under the laws of the State; and

(2) Has bylaws or policies that describe the manner in which the activities or services for which a grant or subsidy is awarded shall be conducted or provided.

Further, a grant or subsidy may be awarded to a non-profit organization only if the organization:

(1) Has been determined and designated to be a non-profit organization by the Internal Revenue Service; and

(2) Has a governing board whose members have no material conflict of interest and serve without compensation.

For a grant or subsidy used for the acquisition of land, when the organization discontinues the activities or services on the land acquired for which the grant or subsidy was awarded and disposes of the land in fee simple or by lease, the organization shall negotiate with the expending agency for a lump sum or installment repayment to the State of the amount of the grant or subsidy used for the acquisition of the land.

Further, the undersigned authorized representative certifies that this statement is true and correct to the best of the applicant's knowledge.

Child & Family Service

[redacted] 1/31/12

(Signature) (Date)

Howard S. Garval, President and CEO

(Typed Name (Title)