**TARRANT COUNTY JUVENILE SERVICES**

**RESIDENTIAL SERVICES**

**RESPONSE FORM**

**ATTACHMENT A**

|  |  |
| --- | --- |
| NAME: | Click here to enter text. |
| BUSINESS ADDRESS: | Click here to enter text. |
| PHONE: | Click here to enter text. |
| EMAIL: | Click here to enter text. |
| FACILITY NAME: | Click here to enter text. |
| FACILITY LOCATION: | Click here to enter text. |

**FACILITY TYPE**

Which type of residential services do you propose to provide? (CHECK ALL THAT APPLY)

[ ]  EMERGENCY SHELTER

[ ]  SHORT TERM RESIDENTIAL

[ ]  SECURE POST-ADJUDICATION CORRECTIONAL FACILITY – Juvenile Board Certified. Select level(s) of care provided:

[ ]  Basic [ ]  Moderate [ ]  Specialized [ ]  Intense

[ ]  NON - SECURE POST-ADJUDICATION CORRECTIONAL FACILITY – Juvenile Board Certified

[ ]  Other:

|  |
| --- |
| Click here to enter text. |

[ ]  RESIDENTIAL PLACEMENT - Texas Department of Family and Protective Services (**TXDFPS)** licensed.

Select level (s) of care provided:

[ ]  Basic [ ]  Moderate [ ]  Specialized [ ]  Intensive

[ ]  DSHS licensed substance abuse treatment program. Select level(s) of care provided:

[ ]  Basic [ ]  Moderate [ ]  Specialized [ ]  Intensive

[ ]  Out of State Provider

[ ]  Secure Residential Licensed by:

|  |
| --- |
| Click here to enter text. |

[ ]  Non-Secure Residential Licensed by:

|  |
| --- |
| Click here to enter text. |

**PROGRAM INFORMATION**

Please describe in as much detail as needed, the following:

1. Philosophy of your agency:

|  |
| --- |
| Click here to enter text. |

1. Type of client your agency works with best:

|  |
| --- |
| Click here to enter text. |

1. Average length of stay:

|  |
| --- |
| Click here to enter text. |

1. Criteria used to determine length of stay:

|  |
| --- |
| Click here to enter text. |

1. Level and frequency of counseling services provided:

|  |
| --- |
| Click here to enter text. |

1. Consideration for and decisions made regarding lowering of a client's Level of Care (other than through Youth for Tomorrow):

|  |
| --- |
| Click here to enter text. |

1. Explain the interventions that will be used with clients who demonstrate at-risk behaviors such as lack of participation or defiant and/or challenging behaviors in order to achieve successful program completion:

|  |
| --- |
| Click here to enter text. |

1. What gender of youth do you serve?

[ ]  Males [ ]  Females

1. What age of youth do you serve?

|  |
| --- |
| Click here to enter text. |

**SPECIALIZED TREATMENT SERVICES**

Check areas of specialized treatment expertise for both male and female juveniles and ***provide supporting documentation*** detailing your tenure and experience with the specialty area(s) selected:

[ ]  Trauma

[ ]  Mental Health

[ ]  Substance Abuse

[ ]  Dual-Diagnosis

[ ]  Intellectual Disabilities or Borderline Functioning IQ’s

[ ]  Reactive Attachment Disorder (RAD)

[ ]  Autism Spectrum

[ ]  Suicidal Ideation (within last 30 days of referral)

[ ]  LGBTQ

[ ]  Young Offenders (10-13 years of age)

[ ]  History of Aggression

[ ]  History of Aggravated or Violent Offenses

[ ]  Sexual Behaviors

[ ]  Commercial Sexual Exploitation

[ ]  Firesetting, Arson or Animal Cruelty

[ ]  Independent Living and/or Vocational Programs (older juveniles)

[ ]  Female specific interventions, especially for those with high risk behaviors

[ ]  Pregnant or Parenting Teens

[ ]  Ability to keep offenders past the age of 18 if on Determinant Sentence Probation

[ ]  Other:

|  |
| --- |
| Click here to enter text. |

**EDUCATION**

Are educational service:

[ ]  On-Campus [ ]  Off-Campus

Who provides the educational services:

|  |
| --- |
| Click here to enter text. |

Is there a strong vocational programming? If yes, describe:

|  |
| --- |
| Click here to enter text. |

**HEALTH & PSYCHIATRIC CARE**

1. Where are emergency medical care obtained:

|  |
| --- |
| Click here to enter text. |

1. Describe who and where routine medical services are delivered:

|  |
| --- |
| Click here to enter text. |

1. Who provides psychiatric service?

|  |
| --- |
| Click here to enter text. |

1. Does your medical/mental health provider bill for Medicaid?

|  |
| --- |
| Click here to enter text. |

**BILINGUAL SERVICES**

1. List any services that can be provided in other languages, describe what languages and the extent of these services:

|  |
| --- |
| Click here to enter text. |

1. Do you serve undocumented youth? If so, what are the potential barriers to serving this population?

|  |
| --- |
| Click here to enter text. |

**STAFF QUALIFICATIONS, LICENSURE AND ACCREDITATION**

Please describe and attach documentation regarding:

1. Staff qualifications, licensure and capacity in which qualified staff works with clients:

|  |
| --- |
| Click here to enter text. |

1. Accreditation certificates, special recognition notices and reference letters.

|  |
| --- |
| Click here to enter text. |

**ACKNOWLEDGMENTS**

**By checking the box by each paragraph, you acknowledge your willingness and ability to abide by each statement.**

[ ]  Acknowledgement to provide monthly reports to TCJS by the 10th day of the month following the month of service, monthly reports are required to include the treatment goals, interventions utilized, and progress made by each TCJS youth in individual or group services.

[ ]  Acknowledgment to provide TCJS and the juvenile’s guardian of notice within 24 hours of any serious incident (including: runaway, escape, medical issues, injury or behavioral issues) by telephone and a follow up in writing to TCJS the next business day.

[ ]  Acknowledgement that parental and TCJS must be notified and approval obtained prior to the administration of any prescription medications or changes in medication.

[ ]  Acknowledgment to provide TCJS notice within 24 hours of licensing violations.

[ ]  Acknowledgment to provide TCJS discharge summaries on the day of discharge or within 24 hours of discharge.

[ ]  Acknowledge that treatment plans and therapy notes will be submitted at an agreed upon time as part of the contracting process. The final report is generally expected one week following the date of the evaluation, unless otherwise specified.

[ ]  Tarrant County Juvenile Services, or its designee, will monitor placement facilities per TJJD standards and will address any deficiencies with facility staff as needed. Failure to correct deficiencies within a reasonable period may result in removal of youth and/or a decision not to place additional youth in that facility.

[ ]  Acknowledgement**, if applicable**, to comply with the Prison Rape Elimination Act, pursuant to 28 CFP, Part 115, section 115.312 (Standards for Juvenile Facilities).

[ ]  Acknowledgement that all juvenile records are confidential, and no records will be released without the expressed consent of TCJS.

[ ]  Acknowledgement that invoices for payment will be based on the daily rate of care contracted. The invoice will include the name of the client, dates of service, daily rate and total amount owed per client on business letterhead with an invoice number. Invoices will be submitted by the 10th of each month for the previous month’s service.

**ATTACHMENTS**

1. Provide a Summary Statement of Respondent’s history, experience and qualifications including cultural diversity of the Respondent's organization as well as a description of cultural sensitivity in the provision of service.
2. Provide copies of sample treatment plans, therapy notes, monthly progress reports and discharge summary. Please provide examples with redacted names.
3. Secure or non-secure correctional facilities provide copy of the last TJJD Monitoring report.
4. Provide information on the number of Abuse, Neglect and Exploitation allegations made to the state during Calendar Year 2019 and the number and type of cases founded as Reason to Believe.
5. Sample incident report.
6. Provide proof of financial stability.
7. Proof of current Licensing or Certification to operate the proposed facility.