SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	Fort Smith Children's Emergency Shelter, Inc.				
Address:	3015 South 14th Street				
City:	Fort Smith	State:	AR	Zip Code:	72901
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship ☐ Corporation		☐ Public Service Corp ☒ Nonprofit	
Minority and Women-Owned Designation*:	☒ Not Applicable ☐ African American	☐ American Indian ☐ Hispanic American	☐ Asian American ☐ Pacific Islander American	☐ Service Disabled Veteran ☐ Women-Owned	
	AR Certification #: _____		* See *Minority and Women-Owned Business Policy*		

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:	Jack Moffett	Title:	Executive Director
Phone:	(479) 783-0018	Alternate Phone:	(479) 242-3860
Email:	jack@fsces.org		

CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.

☒ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☒ Prospective Contractor does not and will not boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract must sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's bid to be disqualified:**

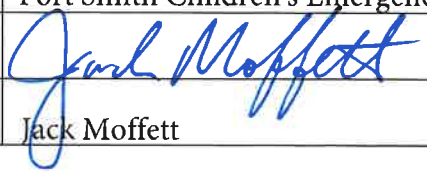
Authorized Signature: Jack Moffett *Use Ink Only.* **Title:** Executive Director

Printed/Typed Name: Jack Moffett **Date:** 3/12/2019

SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation. ***Use Ink Only***

Vendor Name:	Fort Smith Children's Emergency Shelter, Inc.	**Date:**	3/12/2019
Authorized Signature:		**Title:**	Executive Director
Print/Type Name:	Jack Moffett		

SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation. ***Use Ink Only***

Vendor Name:	Fort Smith Children's Emergency Shelter, Inc.	**Date:**	3/12/2019
Authorized Signature:	Jack Moffett	**Title:**	Executive Director
Print/Type Name:	Jack Moffett		

SECTION 3,4,5 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation. ***Use Ink Only***

Vendor Name:	Fort Smith Children's Emergency Shelter, Inc.	**Date:**	3/12/2019
Authorized Signature:		**Title:**	Executive Director
Print/Type Name:	Jack Moffett		

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP
Western Arkansas Counseling and Guidance Center	3111 South 70th Street	Fort Smith, AR 72901

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

By signature below, vendor agrees to and **shall** fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

Vendor Name:	Fort Smith Children's Emergency Shelter, Inc.	**Date:**	3/12/2019
Authorized Signature:	Jack Moffett	**Title:**	Executive Director
Print/Type Name:	Jack Moffett		

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROCUREMENT
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203

ADDENDUM 1

DATE: **March 12, 2019**
SUBJECT: **RFQ 710-19-1025 QUALIFIED RESIDENTIAL TREATMENT PROGRAM**

The following change(s) to the above referenced Competitive Bid for DHS has been made as designated below:

_X_ **Change of specification(s)**
_____ Additional specification(s)
_X_ **Change of bid submission/opening date and time**
_____ Cancellation of bid
_____ Other

BID OPENING DATE AND TIME

Bid opening date change to April 8, 2019. Time remains the same – 10:00 am

Revise 1.28 - Schedule of Events to read: Date and time for Opening Bids: April 8, 2019.

CHANGE TO PAGE ONE OF THE SOLICITATION DOCUMENT

Add contact information;
Issuing Officer: Margurite Al-Uqdah
Email Address: margurite.al-uqdah@dhs.arkansas.gov
Phone#: 501-682-8743

REPLACE ATTACHMENT

Replace Attachment G

CHANGES TO REQUIREMENTS

Delete Section 2.2A and replace with the following:

A. Vendor must submit a Residential Child Welfare Agency license obtained from the Division of Child Care and Early Childhood Education (DCCECE).

Delete Section 2.2B and replace with the following:

B. Must be accredited by one (1) of the independent, not for profit organizations specified below **or** have an application in-progress for one or more such accreditations at time of bid. For verification purposes, the Vendor **must** submit:

1) Current Certificate of Accreditation from one of the organizations listed below **or**

2) A copy of the accreditation application **and** a copy of the application payment that was submitted to one of the entities below:

   a. The Commission on Accreditation of Rehabilitation Facilities (CARF);
   b. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
   c. The Council on Accreditation (COA).

Section 2.3 A

Delete: The contractor must be a licensed residential treatment care provider and be accredited by any of the following independent not-for-profit organizations : The Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA) or The Commission on Accreditation of Rehabilitation Facilities (CARF).

Add: The contractor must be a licensed residential treatment care provider and be accredited by any of the following independent not-for-profit organizations by October 1, 2019: The Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA) or The Commission on Accreditation of Rehabilitation Facilities (CARF).

Attachment C: Performance Standards

C. Delivery of Treatment in a Safe and Secure Environment, add:

Service Criteria:

8. The contractor must be a licensed residential treatment care provider and be accredited by any of the following independent not-for-profit organizations by October 1, 2019: The Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA) or The Commission on Accreditation of Rehabilitation Facilities (CARF).

Acceptable Performance:

Acceptable performance is defined as one hundred percent (100%) compliance with all Service Criteria and Acceptable Performance standards at all times throughout the contract term.

Contractor must maintain accreditation one hundred percent (100%) of the time after October 1, 2019 and for the duration of the contracted term.

Damages:

Failure to achieve and maintain licensure and accreditation as stated in Service Criteria and Acceptable performance my result in immediate contract termination.

The specifications by virtue of this addendum become a permanent addition to the above referenced Invitation for Bid.

FAILURE TO RETURN THIS SIGNED ADDENDUM MAY RESULT IN REJECTION OF YOUR BID.

If you have questions, please contact the buyer Margurite.al-uqdah@dhs.arkansas.gov or 501-682-8743.

Vendor Signature

3/13/2019
Date

Children's Emergency Shelter
Company

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
OFFICE OF PROCUREMENT
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203

ADDENDUM 2

DATE: **March 26, 2019**
SUBJECT: 710-19-1025 Qualified Residential Treatment Program

The following change(s) to the above referenced Competitive Bid for DHS has been made as designated below:

__X__ **Change of specification(s)**
_____ Additional specification(s)
_____ **Change of bid submission/opening date and time**
_____ Cancellation of bid
__X__ Other

BID OPENING DATE AND TIME

Bid opening date and time

CHANGE EFFECTIVE DATE OF CONTRACT

Revise
Sections 1.2A Type of Contract and Section 1.28 - Contract Start Date which reads that the effective date of contract is 6/1/2019.

It will now read to say contract effective date is 7/1/2019.

CHANGE SPECIFICATIONS

2.1 QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) MINIMUM QUALIFICATIONS

Insert at the end of item "D.": Vendors who do not have registered or licensed nursing personnel at time of bid submission must submit all licenses before July 1, 2019, in order to be awarded a contract.

REVISE ATTACHMENT

Revise Attachment G

The specifications by virtue of this addendum become a permanent addition to the above referenced Invitation for Bid.

FAILURE TO RETURN THIS SIGNED ADDENDUM MAY RESULT IN REJECTION OF YOUR BID.

If you have questions, please contact the buyer Margurite.al-uqdah@dhs.arkansas.gov or 501-682-8743.

Vendor Signature

3/26/2019
Date

Children's Emergency Shelter
Company

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☒ Yes ☐ No

SUBCONTRACTOR NAME: Fort Smith Children's Emergency Shelter

TAXPAYER ID NAME: 71-0779347

IS THIS FOR: ☐ Goods? ☒ Services? ☐ Both?

YOUR LAST NAME: Moffett FIRST NAME: Jack M.I.: L

ADDRESS: 3015 South 14th Street

CITY: Fort Smith STATE: AR ZIP CODE: 72901 COUNTRY: USA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee							

☒ None of the above applies

FOR AN ENTITY (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly	✓		Representative	1/19		Jay Richardson	0	Board Mem
Constitutional Officer								
State Board or Commission Member								
State Employee								

☐ None of the above applies

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature Jack Moffett Title Executive Director Date 3/11/2019

Vendor Contact Person Jack Moffett Title Executive Director Phone No. 479-783-0018

Agency use only

Agency Number _____ Agency Name _____ Agency Contact Person _____ Contact Phone No. _____ Contract or Grant No. _____

Policy Name
Equal Employment

Policy Section
II: Hiring and Separation

Policy Number
202 (Page **1** of **1**)

Date written/revised
June, 2003

Policy

It is the Fort Smith Children's Emergency Shelter's policy to comply with the Title VI of the 1964 Civil Rights Law and to follow the guidelines of the Equal Employment Opportunities Commission currently in force. No person or group of persons shall be discriminated against in employment, which includes recruiting, hiring and promoting employees, on the basis of race, color, religion, sex, creed, handicap/disability, age, national origin, political affiliation or in any manner be excluded from participation in or be denied the benefits of any program or activity supported by funds administered by this organization.

Procedures

Fort Smith Children's Emergency Shelter does not discriminate on the basis of race, religion, national origin, gender, age, marital status, or physical or mental handicap. It recruits, hires and promotes on the basis of individuals qualifications and performance. Any employee who believes that s/he has been a victim of discrimination or sexual harassment may avail herself/himself of the procedures described in Policy Numbers 601 and 602 of this manual.

THE ARKANSAS CHILD WELFARE AGENCY REVIEW BOARD

In cooperation with

The Arkansas Department of Human Services'

Division of Child Care and Early Childhood Education

Certifies that

Fort Smith Children's Emergency Shelter
Owner

Fort Smith Children's Emergency Shelter
Agency

3015 SO 14TH

FORT SMITH, AR 72901

Is hereby issued Residential license #: 182

FOR THE PURPOSE OF OPERATING, IN THE STATE OF ARKANSAS, THE FOLLOWING:

Emergency Residential Child Care Facility FOR 24 CHILDREN AGES 5 TO 18

THIS IS A REGULAR LICENSE WITH AN EFFECTIVE DATE OF 10/28/1998 AND WILL REMAIN IN EFFECT UNLESS THERE IS A STATUS CHANGE.

In Witness whereof

Chairman, Child Welfare Agency Review Board

Effective: 10/28/1998

CARF INTERNATIONAL

Survey Application Submittal Confirmation Original

Children's Emergency Shelter
Fort Smith, AR
US
Company Number: 309410
Survey Number: 117371
Survey Application Submittal Date: 2019-03-29

Congratulations! You have successfully submitted your survey application. Review the Next Steps section below for important information. Print a copy of this confirmation for your records. A copy has also been emailed to the Survey Key Contact.

Next Steps

Application Fee
Payment Method: Credit Card
Application Fee: $995.00 USD
Total Invoice Amount: $995.00 USD

If you are paying by credit card, you will receive a separate email confirming that payment went through. If you do not receive a separate confirmation, please contact CARF at (888) 281-6531.

Thank you for completing the survey application online. Part of CARF's corporate responsibility is its commitment to the environment. In order to minimize the reliance on paper, CARF's primary means of transmitting certain documents, such as the survey fee invoice and quality improvement plan, is by posting them on Customer Connect, our secure, dedicated website for accredited organizations and organizations seeking accreditation. Email notification is sent to each organization's identified Survey Key Contact when documents have been posted. Please use Customer Connect regularly to view accreditation- and survey-related documents and to keep CARF informed of email address changes. Over time, CARF intends to increase the number of documents posted to Customer Connect.

By providing detailed information about your organization and its programs, you will help us coordinate your survey and assist the surveyors to better understand your organization. Once payment is processed, please allow approximately 45 days for us to review your survey application and determine the appropriate team size and number of days required for your survey. We will send you an invoice for the survey fee when the review is complete. Please promptly contact us if you need to update or correct any information or if you have any questions about the accreditation process.

Thank you for your commitment to quality in human services. We are proud to work with your organization in this endeavor.

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

CHILDREN'S Emergency Shelter

Jack Moffett <jack@fsces.org>

Order Confirmation

1 message

bookstore@carf.org <bookstore@carf.org> Thu, Mar 28, 2019 at 10:06 AM
To: jack@fsces.org

Thank you for your online payment.

Merchant: CARF International

Order ID: AK0A6C6EB50B
Order Placed: Thursday, March 28, 2019, 08:06:14 AM MDT

Amount of Transaction: $995.00
Payment Type: Visa

BILL TO

Jack Moffett
3015 S. 14th
Fort Smith
AR
US
4797830018
jack@fsces.org

ORDER DESCRIPTION:

Application Fee for Survey 117371, Company 309410, CSU CYS - Children's Emergency Shelter
---

www.carf.org

CARF International, 6951 E Southpoint Road, Tucson, AZ 85756-9407, USA
Toll Free: (888) 281-6531, Fax: (520) 318-1129

CARF Canada, 501-10154 104 Street NW, Edmonton AB T5J-1A7, CANADA
Toll Free: (888) 281-6531, Fax: (780) 426-7274

CARF Europe, 4th Floor, Rex House, 4-12 Regent Street, London SW1Y 4RG, UK
Phone: +001 (520) 325-1044, Fax: +001 (520) 318-1129
A charitable company limited by guaranty, registered in England and Wales. Company #06772442, Charity #1134454

carf INTERNATIONAL

Survey Application

ORGANIZATION INFORMATION

ORGANIZATION TO BE SURVEYED

Organization/Unit Name	Acronym	Federal Tax Identification Number
Children's Emergency Shelter	CES	71-0779347

Organization Website (Example: www.carf.org)	Telephone (Example: 520-325-1044)	Fax (Example: 520-318-1129)
www.childrensemergencyshelter.org	479-783-0018	479-783-1873

Street Address (no P.O. Box)	Suite Number, Floor, Department, or OTHER	City
3015 South 14th Street		Fort Smith

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)
US	AR	

Zip/Postal Code	County
72901	

ORGANIZATION CHARACTERISTICS

Total annual operating revenue for the organization being surveyed	Annual operating revenue for the programs seeking accreditation	Fiscal Year End
943,665.00	943,665.00	06/30

Select all locales or communities served that apply.

Check all that apply.	Locale	Description
☐	Metropolitan	
☐	Rural	
☐	Urban	
☑	Multiple Counties	Entire state of Arkansas is served
☐	Multiple States/Provinces	
☐	International	
☐	Other	

Identify any company affiliations your organization has.

Check all that apply.	Company Affiliation (if any)	Description
☐	Health Care System (Hospital System)	
☐	Military	
☐	Religious	
☐	University	

Ownership Type

☐ Government Entity ☑ Private, not for profit ☐ Private, for profit
☐ Publicly traded ☐ Sole Proprietor ☐ Other

Other Ownership Description

Type of Government Entity

- ☐ Federal/Non-VA
- ☐ State
- ☐ Province/Territory
- ☐ Other
- ☐ County/Municipality
- ☐ Tribal
- ☐ District
- ☐ Region
- ☐ City
- ☐ Veterans Health Administration

Other Government Entity Description

The following question is for surveys using the medical rehabilitation standards manual.

Is your organization licensed as a freestanding rehabilitation hospital in the United States?

- ☐ Yes
- ☐ No

The following question is for surveys using the DMEPOS standards manual.

Total annual DMEPOS billings to CMS

The following questions are ONLY for surveys that include the program Continuing Care Retirement Community.

Investment Banking Firm

Audit Firm

Credit Rating Agency

Credit Rating

- ☐ A
- ☐ A-
- ☐ A+
- ☐ AA
- ☐ AA-
- ☐ AA+
- ☐ AAA
- ☐ AAA-
- ☐ AAA+
- ☐ B
- ☐ B-
- ☐ B+
- ☐ BB
- ☐ BB-
- ☐ BB+
- ☐ BBB
- ☐ BBB-
- ☐ BBB+

CORPORATE STRUCTURE

1. Is your organization a unit or department within a larger entity (i.e., not a distinct legal entity and has the same federal tax identification number as the larger entity)?

- ☐ Yes
- ☑ No

If you answered "yes" to the above question, provide the information below about the larger entity, then proceed to question 2. If you answered "no," proceed to question 3.

Name of larger entity

Street Address (no P.O. Box)

Suite Number, Floor, or Department

City

State/Province/Territory

Zip/Postal Code

Country

Briefly describe the larger entity and how your programs fit into its operations.

2. If your organization is a unit or department within a larger entity, is the larger entity a subsidiary of a parent company (i.e., a distinct legal entity with a separate federal tax identification number from the parent company)?

- ☐ Yes
- ☑ No

If you answered "yes" to the above question, provide the information below about the parent company and proceed to the next section. If you answered "no," proceed to the next section.

Name of Parent Company	Street Address (no P.O. Box)	Suite Number, Floor, or Department
City	**State/Province/Territory**	**Zip/Postal Code**
Country	**Federal Tax Identification Number**	

3. If your organization is not a unit or department within a larger entity, is it a subsidiary of a parent company (i.e., a distinct legal entity with a separate federal tax identification number from the parent company)?

☐ Yes
☑ No

If you answered "yes" to the above question, provide the information below about the parent company. If you answered "no," proceed to the next section.

Name of Parent Company	Street Address (no P.O. Box)	Suite Number, Floor, or Department
City	**State/Province/Territory**	**Zip/Postal Code**
Country	**Federal Tax Identification Number**	

SIGNIFICANT CHANGES/EVENTS

Indicate if your organization experienced any significant changes or events in the past year for the programs seeking accreditation.

Change/Event Type	Yes/No	Explanation
Change in leadership	☑ No ☐ Yes ☐ Yes, previously submitted	
Change in ownership	☑ No ☐ Yes ☐ Yes, previously submitted	
Organization name change	☑ No ☐ Yes ☐ Yes, previously submitted	
Change in mailing and/or e-mail addresses	☑ No ☐ Yes ☐ Yes, previously submitted	
Significant reorganization of personnel	☑ No ☐ Yes ☐ Yes, previously submitted	
Relocation, expansion, or elimination of program, service, or site	☑ No ☐ Yes ☐ Yes, previously submitted	
Severe financial distress	☑ No ☐ Yes ☐ Yes, previously submitted	
Merger, consolidation, joint venture, acquisition of accredited program/service	☑ No ☐ Yes ☐ Yes, previously submitted	
Investigations	☑ No ☐ Yes ☐ Yes, previously submitted	
Material litigation	☑ No ☐ Yes ☐ Yes, previously submitted	
Catastrophes	☑ No ☐ Yes ☐ Yes, previously submitted	
Sentinel events	☑ No ☐ Yes ☐ Yes, previously submitted	
Governmental sanctions, bans on admissions, fines, penalties, loss of programs	☑ No ☐ Yes ☐ Yes, previously submitted	

SOURCES OF FUNDING/REFERRAL

Please identify your sources of funding and/or ongoing referrals such as local, county, tribal, provincial, territorial, federal, or private.

Category	Funding	Referral	Name of Funding/Referral Source
Alcohol and Other Drug Programs	☐	☐	
Area Agency on Aging	☐	☐	
Bureau of Indian Affairs	☐	☐	
Case Management System	☐	☐	
Child Welfare Agency	☑	☑	Arkansas Department of Children and Family Services
Churches	☐	☐	
Community Living British Columbia (CLBC)	☐	☐	
U.S. Department of Defense	☐	☐	
Developmental Disabilities Agency	☐	☐	
Employer	☐	☐	
Health Canada	☐	☐	
Indian and Northern Affairs Canada	☐	☐	
Local Health Integration Network	☐	☐	
Long-Term Care Insurance	☐	☐	
Managed Care - HMO	☐	☐	
Managed Care - IPA/IPP	☐	☐	
Managed Care - Other	☐	☐	
Managed Care - PPO	☐	☐	
Medicaid/MediCal/AHCCCS	☐	☐	
Medicare	☐	☐	
Mental Health Agency	☐	☐	
Mental Health Programs	☐	☐	
Mental Health Regional Authority	☐	☐	
Ministry of Children and Family Development	☐	☐	
Ministry of Health	☐	☐	
Ministry Responsible for Seniors	☐	☐	
Municipality/Provincial/Territorial Med. Ins. Plan	☐	☐	
Older Americans Act	☐	☐	
Private Medical Insurance	☐	☐	
Private Pay	☐	☐	
Provincial Ministry of Social/Community Services	☐	☐	
Regional Health Authority	☐	☐	
Self-Insured Employer	☐	☐	
Self-Pay/Self-Referral	☐	☐	
Veterans Health Administration	☐	☐	
Vocational Rehabilitation Agency	☐	☐	
Workers' Compensation/Workers' Compensation Board	☐	☐	
Workforce Development Board	☐	☐	
Other Provincial Ministry of Children's Services	☐	☐	
Other	☐	☐	

List at least one, preferably two, external funding/referral sources with whom your organization works and from whom we can request confidential information regarding the quality of services provided by your organization.

OTP organizations must list a State Methadone Authority contact.

FUNDING/REFERRAL Reference #1

Title Ms.	**First Name** Brenna	**Middle Initial**
Last Name Myers	**Suffix (Jr., Sr., etc.)**	**Credentials**
Work Telephone 4797824555	**Extension** 3243	**E-mail Address** brenna.myers@dhs.arkansas.gov
Job Title DCFS Supervisor		
Organization Name Sebastian County DCFS		
Mailing Address 616 Garrison Avenue	**Suite Number, Floor, Department, or OTHER**	**City** Fort Smith
Country US	**State/Province/Territory** AR	**OTHER State/Province/District (outside North America Only)**
Zip/Postal Code 72901	**County** Sebastian	

FUNDING/REFERRAL Reference #2

Title Ms.	**First Name** Megon	**Middle Initial**
Last Name Bush	**Suffix (Jr., Sr., etc.)**	**Credentials**
Work Telephone	**Extension**	**E-mail Address** megon.bush@dhs.arkansas.gov
Job Title		
Organization Name		
Mailing Address 700 Main Street	**Suite Number, Floor, Department, or OTHER**	**City** Little Rock
Country US	**State/Province/Territory** AR	**OTHER State/Province/District (outside North America Only)**
Zip/Postal Code 72201	**County**	

INFORMATION AND OUTCOMES MANAGEMENT (IOM)

Identify any outcomes systems used.

Check all that apply.	Name	Description
☐	Activity Measure-Post Acute Care (AM-PAC)	
☐	eRehabData	
☐	Focus on Therapeutic Outcomes (FOTO)	
☐	IT Healthtrack	
☐	MedTel Outcomes	
☐	National Outcomes Measurement System (NOMS)	
☐	Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL)	
☐	ProMOS System/RehabCare	
☐	UDS/LifeWare	
☐	UDS-PRO/UDSMR	
☐	Other pooled data system (specify)	
☑	None	

Identify any outcomes tools/measures used.

Check all that apply.	Name	Description
☐	Canadian Occupational Performance Measure (COPM)	
☐	Community Integration Questionnaire (CIQ)	
☐	Craig Handicap Assessment Rehab Tool (CHART)	
☐	Diener Satisfaction with Life Survey (SWLS)	
☐	Disabilities of the Arm, Shoulder and Hand (DASH) Outcome Measure	
☐	Disability Rating Scale (DRS)	
☐	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)	
☐	Mayo-Portland Adaptability Inventory (MPAI-3, MPAI-4)	
☐	Minimum Data Set (MDS)	
☐	Neck Disability Index (NDI)	
☐	Oswestry Disability Index	
☐	Roland Morris Disability Questionnaire	
☐	SF-12/SF-36	
☐	Supervision Rating Scale (SRS)	
☐	Visual Analog Scale/Pain Rating Scale	
☐	Other published outcome tool (specify)	
☐	Organization-developed/unpublished outcome tool	

Identify any satisfaction tools used.

Check all that apply.	Name	Description
☐	Avatar Patient Survey	
☐	Gallup Patient Quality System/Patient Satisfaction	
☐	Jackson Group Customer/Patient Satisfaction	
☐	National Research Corp (NRC+Picker) Patient Satisfacton	
☐	Press Ganey Patient/Resident Satisfaction	
☐	Professional Research Consultants (PRC) Patient/Consumer Perception Survey	
☐	uSPEQ Consumer Experience Survey	
☐	uSPEQ Employee Climate Survey	
☐	Other published patient satisfaction (specify)	
☐	Other published stakeholder satisfaction (specify)	
☐	Organization-developed/unpublished satisfaction tool	

SURVEY KEY CONTACT

CONTACT INFORMATION

Title	First Name	Middle Initial
Ms.	Emiko	

Last Name	Suffix (Jr., Sr., etc.)	Credentials
Curry		

Job Title	E-mail Address
Director of Operations	acurry@fsces.org

Work Telephone	Extension	Fax
479-353-6888		

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address	Suite Number, Floor, Department, or OTHER	City
3015 South 14th Street		Fort Smith

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)
US	AR	

Zip/Postal Code	County
72901	

ORGANIZATION INFORMATION

☑ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box)	Suite Number, Floor, Department, or OTHER	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

ACCREDITATION LIAISON

CONTACT INFORMATION

☑ Same as Survey Key Contact

Title

First Name

Middle Initial

Last Name

Suffix (Jr., Sr., etc.)

Credentials

Job Title

E-mail Address

Work Telephone

Extension

Fax

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address

Suite Number, Floor, Department, or OTHER

City

Country

State/Province/Territory

OTHER State/Province/District (outside North America Only)

Zip/Postal Code

County

ORGANIZATION INFORMATION

☐ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box)

Suite Number, Floor, Department, or OTHER

City

Country

State/Province/Territory

OTHER State/Province/District (outside North America Only)

Zip/Postal Code

County

AFTER-HOURS CONTACT

CONTACT INFORMATION

☑ Same as Survey Key Contact

Title	First Name	Middle Initial

Last Name	Suffix (Jr., Sr., etc.)	Credentials

Job Title	E-mail Address	After-Hours Telephone
		4793536888

Work Telephone	Extension	Fax

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address	Suite Number, Floor, Department, or OTHER	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

ORGANIZATION INFORMATION

☐ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box)	Suite Number, Floor, Department, or OTHER	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

TRAVEL & LODGING CONTACT

CONTACT INFORMATION

☑ Same as Survey Key Contact

Title	First Name	Middle Initial

Last Name	Suffix (Jr., Sr., etc.)	Credentials

Job Title	E-mail Address

Work Telephone	Extension	Fax

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address	Suite Number, Floor, Department, or OTHER	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

ORGANIZATION INFORMATION

☐ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box)	Suite Number, Floor, Department, or OTHER	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

INFORMATION & OUTCOMES MANAGEMENT (IOM) CONTACT

CONTACT INFORMATION

☑ Same as Survey Key Contact

Title | First Name | Middle Initial

Last Name | Suffix (Jr., Sr., etc.) | Credentials

Job Title | E-mail Address

Work Telephone | Extension | Fax

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address | Suite Number, Floor, Department, or OTHER | City

Country | State/Province/Territory | OTHER State/Province/District (outside North America Only)

Zip/Postal Code | County

ORGANIZATION INFORMATION

☐ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box) | Suite Number, Floor, Department, or OTHER | City

Country | State/Province/Territory | OTHER State/Province/District (outside North America Only)

Zip/Postal Code | County

FINANCE CONTACT (ONLY REQUIRED FOR CCRC PROGRAM)

CONTACT INFORMATION

☑ Same as Survey Key Contact

Title | First Name | Middle Initial

Last Name | Suffix (Jr., Sr., etc.) | Credentials

Job Title | E-mail Address

Work Telephone | Extension | Fax

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address | Suite Number, Floor, Department, or OTHER | City

Country | State/Province/Territory | OTHER State/Province/District (outside North America Only)

Zip/Postal Code | County

ORGANIZATION INFORMATION

☐ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box) | Suite Number, Floor, Department, or OTHER | City

Country | State/Province/Territory | OTHER State/Province/District (outside North America Only)

Zip/Postal Code | County

COMPANY LEADERSHIP

CONTACT INFORMATION

☐ Same as Survey Key Contact

Title	First Name	Middle Initial

Last Name	Suffix (Jr., Sr., etc.)	Credentials

Job Title	E-mail Address

Work Telephone	Extension	Fax

☐ List this person on the final survey report.

☐ Separate mailing address/post office box (complete fields below).

Mailing Address	Suite Number, Floor, Department, or OTHER	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

ORGANIZATION INFORMATION

☐ Same as Organization to Be Surveyed

Organization Name

Street Address (no P.O. Box)	Suite Number, Floor,	City

Country	State/Province/Territory	OTHER State/Province/District (outside North America Only)

Zip/Postal Code	County

STATISTICS AND DEMOGRAPHICS

PERSONNEL

Information reported below is for all programs seeking accreditation and should be reported in numbers (not percentages). Estimate if data are not available. This information is used to help us in assigning the survey team.

Total Full-Time Equivalent (FTE) Personnel

13.00

Actual number of direct-service personnel

Employees

15

Contracted Personnel

Volunteers

1

Total Direct-Service Personnel

16

PERSONS SERVED

If using the DMEPOS standards manual, skip this section.

Information reported below is for all programs seeking accreditation and should be reported in numbers served annually (not percentages). Estimate if data are not available. This information is used to help us in assigning the survey team.

Total Number of Persons Served Annually

170

Race/Ethnicity	Number of Persons Served	Other Race/Ethnicity Description
African American/Black	24	
Asian	1	
White	122	
First Nation/Aboriginal Canadian	0	
Hispanic/Latino (Ethnicity)	20	
Native (American or Alaskan)	1	
Native Hawaiian or Other Pacific Islander	2	
Other(s), specify		

Gender	Number of Persons Served
Female	95
Male	75
Unknown Gender	

Age	Number of Persons Served	Other Age Description
0-5 (Children)		
06-17 (Adolescent)	170	
18-40 (Adult)		
41-65 (Adult)		
66-85 (Adult)		
86+ (Adult)		
Other Age Group		
Unknown Age Group		

Information should be reported in numbers served annually (not percentages). If the categories do not represent your organization, please utilize the other or unknown fields.

Completion of the grid below is required if your survey will be conducted using the behavioral health, child and youth services, employment and community services, or opioid treatment standards manual.

Other Characteristics of Persons Served	Number of Persons Served	Other Description
Acquired Brain Injury	0	
Alcohol and/or Other Addictions	0	
Developmental Disabilities	0	
Dual Diagnosis - AOD/DD	0	
Dual Diagnosis - AOD/MH	0	
Dual Diagnosis - MH/DD	0	
Hearing Impairments	0	
HIV positive/AIDS	0	
Homeless Individuals	170	
Mental Disorders	0	
New Immigrants	0	
Other Addictions	0	
Physical Disabilities	0	
Unemployed/Underemployed	0	
Visual Impairments	0	
Other Characteristic	0	
Dementia	0	
Unknown Characteristics	0	
Autism Spectrum Disorder	0	

Additional information regarding the community, population, or cultures you serve that would be helpful.

BENEFICIARIES SERVED (DMEPOS only)

Information reported below is for all product categories seeking accreditation and should be reported in numbers served annually (not percentages). Estimate if data are not available. This information is used to help us in assigning the survey team.

Total Number of Beneficiaries Served Annually

Race/Ethnicity	Number of Beneficiaries Served	Other Race/Ethnicity Description

Gender	Number of Beneficiaries Served

Age	Number of Beneficiaries Served	Other Age Group Description

Additional information regarding the community, population, or cultures you serve that would be helpful.

INFORMATION FOR SCHEDULING

COLLABORATIVE/RELATED SURVEYS

CARF/EAGLE Collaborative Survey

☐

Are there any other surveys that should be considered when scheduling this survey?

☐ Yes

☑ No

If yes, please describe.

STANDARDS MANUAL

Primary Standards Manual

2019 Child and Youth Services

Identify additional standards manuals only if you are applying for a blended survey.

Additional Standards Manual(s)

TIME FRAME AND PROBLEM DATES

Use the grid below to confirm the time frame for your survey. DMEPOS surveys do not need to complete the time frame fields.

Organizations requiring large survey teams may be asked to submit applications early.

Expiration Month	Preferred Time Frame	Survey Application Submitted No Later Than:
August	July - August	February 28/29
September	July - August	February 28/29
October	August - September	April 30
November	September - October	May 31
December	October - November	June 30
January	November - December	July 31
February	December - January	August 31
March	January - February	September 30
April	February - March	October 31
May	March - April	November 30
June	April - May May - June	December 31

A consecutive two-month time frame with no fewer than four open weeks is required. Refer to the grid above.

Time Frame Start Date

9/1/2019

Time Frame End Date

10/31/2019

Indicate any problem dates or time periods in this time frame that would pose significant problems for your organization. If there are no problem dates, enter "none."

None

Would a Friday/Saturday survey be acceptable? Select Yes only if the programs/services seeking accreditation are regularly provided on Saturdays

- [x] Yes
- [ ] No

Saturday hours of operation

24 hours per day

CONFLICTS OF INTEREST

Have any CARF International surveyors served as consultants to your organization in the last four years?

- [ ] Yes
- [x] No

If yes, please list names.

Would surveyors from any specific states/provinces/territories represent a conflict of interest? (DMEPOS surveys, choose N/A option.)

- [ ] Yes
- [x] No
- [ ] N/A

If yes, please list the states/provinces/territories.

Would you accept one team member being assigned to your survey from your own state/province/territory, if outside of North America, from your own country? (DMEPOS surveys, choose N/A option)

- [x] Yes
- [ ] No
- [ ] N/A

Are there any organizations/suppliers considered to be in direct competition with your organization?

- [ ] Yes
- [x] No

If yes, please list the organizations/suppliers.

Are there any geographical areas outside of your state/province/territory from which referrals or significant funding is received? (DMEPOS surveys, choose N/A option.)

- [ ] Yes
- [x] No
- [ ] N/A

If yes, please list the geographical areas.

Are any of your organization's employees current or former CARF International surveyors?

- [ ] Yes
- [x] No

If yes, please list names.

Are there any other potential conflicts of interest to avoid?

- [ ] Yes
- [x] No

If yes, please specify.

HOTEL INFORMATION

Recommend two nearby hotels or motels for the survey team. Provide hotel information for all cities where an overnight stay may be required.

HOTEL

☑ **Preferred**

Hotel Name	Street Address	
Doubletree	700 Rogers Avenu	
City	**State/Province/Territory**	**Zip/Postal Code**
Fort Smith	AR	72901
Telephone	**Fax**	**Distance to Survey Headquarters**
4797831000		2.1 miles

Other Notes/Instruction

HOTEL

☐ **Preferred**

Hotel Name	Street Address	
Courtyard	900 Rogers	
City	**State/Province/Territory**	**Zip/Postal Code**
Fort Smith	AR	72901
Telephone	**Fax**	**Distance to Survey Headquarters**
4797832100		2 miles

Other Notes/Instruction

AIRPORT INFORMATION

Provide information for the nearest or most convenient commercial airport for all cities where flights may be required.

Nearest/Most Convenient Airport	Name and City	Distance/Time from Hotels	Other Notes/Instructions
☑	Fort Smith Regional Airport, Fort Smith	5 miles/12 minutes	

OTHER SURVEY LOGISTICS

Will your organization provide transportation for surveyors between survey locations?

☐ Yes
☑ No

Provide any additional information that may assist us in arranging your survey logistics.

PROGRAMS TO BE SURVEYED

GOVERNANCE STANDARDS APPLICABILITY

Do you elect to have the governance standards applied?

☐ Yes
☑ No

Note: If this survey includes the program Continuing Care Retirement Community, governance standards must be applied. If you are using the DMEPOS standards manual, governnance standards are not applicable.

INFORMATION AND COMMUNICATIONS TECHNOLOGIES STANDARDS APPLICABILITY

Does your organization use information and communication technologies, also known as telepractice, telehealth, telemental health, telerehabilitation, telespeech, etc., for service delivery in the programs or services for which you are seeking accreditation?

☑ Yes
☐ No

NOTE: If information and communications technologies are utilized for service delivery in any of the programs or services for which you are seeking accreditation, standards J.2-8 in Section 1 must be applied.

PROGRAMS TO BE SURVEYED

The grid below identifies the program(s) that are a part of this survey.

Standards Manual	Program
2019 Child and Youth Services	Group Home - Children and Adolescents

PROGRAMS NOT BEING SURVEYED

The grid below identifies the program(s) removed from this survey.

Program	Reason for Removing Program	Other Description

CHILD AND YOUTH SERVICES PROGRAM INFORMATION

Total number of persons served annually

Number of locations where this program is provided
1

Direct-service personnel in full-time equivalents (FTEs)

Does this program provide medication use?
- ☑ Yes
- ☐ No

Does this program use any nonviolent practices such as seclusion or restraint?
- ☐ Yes
- ☑ No

Does this program offer peer support?
- ☐ Yes
- ☑ No

Does this program have a child welfare focus?
- ☑ Yes
- ☐ No

Terminology your organization uses to identify this program

Our shelter provides emergency short-term shelter for abused and neglected children, ages 6-17, in the state of Arkansas. We provide a safe and caring home-like environment for up to 24 children per day.

Does this program/service use Electronic Health/Medical Records for persons served?
- ☐ Yes
- ☑ No

LOCATIONS FOR SURVEY

Complete the Programs to Be Surveyed tab before entering or updating Locations for Survey. You must include locations that are owned, leased, or controlled/operated by your organization for the administration or provision of the programs/services for which you are seeking accreditation.

LOCATIONS FOR SURVEY

The grid below identifies the location(s) that are a part of this survey.

Location Name	Street Address	City	State/Province/Territory
Children's Emergency Shelter	3015 South 14th Street	Fort Smith	AR

LOCATIONS NOT PART OF SURVEY

The grid below identifies the location(s) removed from this survey.

Location Name	Street Address	City	State/Province/ Territory	Reason for Removing Location	Other Description	Effective Date

LOCATION

LOCATION INFORMATION

Location Name
Children's Emergency Shelter

Does this location operate solely as an administrative site?
☐ Yes
☐ No

Street Address (no P.O. Box)
3015 South 14th Street

Suite Number, Floor, Department, or OTHER

City
Fort Smith

Country
US

State/Province/Territory
AR

OTHER State/Province/District (outside North America Only)

Zip/Postal Code
72901

County

Telephone
479-783-0018

Is this location acting as the survey headquarters?
☑ Yes
☐ No

Is WiFi available for the survey team's use at this location?
☑ Yes
☐ No

Distance from survey headquarters

Miles or kilometres?

Direction from survey headquarters

Describe any accessibility issues at the location.
None

Location Type
☑ Owned/leased
☐ Donated space under program's control/operation

Do you want this location's address and phone number to be published in our listings of accredited organizations?
☑ Yes, publish
☑ No, do not publish

Days and Hours of Operation
☐ 8:00 a.m. - 5:00 p.m., Monday - Friday
☑ 24 hours a day, 7 days a week
☐ Other

Other Days/Hours Description

If any program/service is provided at this location during limited days/hours, list the CARF program name and description of days/hours of operation

Direct-service personnel in full-time equivalents (FTEs) at this location for the programs seeking accreditation
13.00

Average number of persons served daily at this location for the programs seeking accreditation
12

STAFF MEMBER RESPONSIBLE FOR OPERATIONS

Same as Survey Key Contact
☑

First Name

Last Name

Credentials

Job Title

Work Telephone

Extension

E-mail Address

PROGRAMS AT THIS LOCATION

The grid below identifies the program(s) to be surveyed at this location.

Program
Group Home - Children and Adolescents

PROGRAMS REMOVED FROM LOCATION

The grid below identifies the program(s) removed from this location.

Program	Reason For Removing Program	Other Description	Effective Date

OTHER INFORMATION

REQUIREMENTS/INCENTIVES TO SEEK ACCREDITATION

Identify any entities that require or provide incentives for your organization to attain CARF International accreditation.

Check all that apply.	Entity Type	Entity Name
☐	Area Agency on Aging	
☐	Case Management Companies	
☐	Employers	
☐	Federal Government	
☑	State/Province/Territory Government	Department of Human Services Division of Children
☐	Managed Care Organizations	
☐	Insurance Companies	
☐	Other Funding Sources	
☐	Other	

OTHER ACCREDITATION/LICENSURE

List any current accreditation, licensure, or reviews.

Check all that apply.	Accrediting Body	Description	Expiration Date
☐	AAAHC (Accreditation Association for Ambulatory Health Care)		
☐	AAPM (American Academy of Pain Management)		
☐	ACA (American Correctional Association)		
☐	Accreditation Canada		
☐	AOA (American Osteopathic Association)		
☐	ASHA (American Speech-Language Hearing Association)		
☐	CAHC (Commission on Accreditation for Home Care)		
☐	CAP (College of American Pathologists)		
☐	CARF International (CARF, CARF Canada, CARF Europe)		
☐	CHAP (Community Health Accreditation Program)		
☐	COA (Council on Accreditation)		
☐	DNV (DNV Healthcare)		
☐	EAGLE (Educational Assessment Guidelines Leading toward Excellence)		
☐	ICCD (International Center for Clubhouse Development)		
☐	ISO (International Organization for Standardization)		
☐	JCAHO (The Joint Commission)		
☐	JCI (Joint Commission International)		
☐	NAEYC (National Association for the Education of Young Children)		
☐	NCQA (National Committee for Quality Assurance)		
☐	RSAS (Rehabilitation Services Accreditation System)		
☐	The Council		
☐	URAC (American Accreditation HealthCare Commission)		
☐	Other		

Other Licensing and Reviews
State of Arkansas Placement and Residential Licens

GROUPS

Identify if your organization is a member of or affiliated with any entity.

Check all that apply.	Group	Description
☐	AA	
☐	AACRC	
☐	AAIDD	
☐	AAN	
☐	AAOS	
☐	AAPM	
☐	AAPM&R	
☐	AARP	
☐	AATOD	
☐	ACCSES	
☐	ACRM	
☐	AHA	
☐	AHCA/NCAL	
☐	AJFCA	
☐	AKTA	
☐	ALFA	
☐	AMRPA	
☐	AMTA	
☐	ANCOR	
☐	AOTA	
☐	APA	
☐	APHSA	
☐	APSE	
☐	APTA	
☐	Arc	
☐	ARF	
☐	ARN	
☐	ASHA (Seniors Housing)	
☐	ASHA (SLP)	
☐	ATRA	
☐	BIA	
☐	CCCF	
☐	CHSA	
☐	CMHA	
☐	CMSA	
☐	CWLA	
☐	CWLC	
☐	ES	
☐	FFTA	
☐	FNCFCS	
☐	FREDLA	
☐	GII	
☐	IAJVS	
☐	IFCO	
☐	IFCW	
☐	LeadingAge	
☐	MHCA	
☐	NAADAC	
☐	NAATP	
☐	NACAC	
☐	NACBH	
☐	NADD	
☐	NADSA	
☐	NAMI	

☐	NAPCWA	
☐	NASW	
☐	National Council	
☐	National Federation	
☐	NCFA	
☐	NICWA	
☐	NOSAC	
☐	NRA	
☐	NSA	
☐	Other	
☐	PPA	
☐	PRA	
☐	PVA	
☐	SourceAmerica	
☐	SPA	
☐	SSVF	
☐	The Alliance	
☐	UCPA	
☐	United Spinal	
☐	UWW	
☐	VHA	
☐	VOA	

ACCREDITATION DECISION NOTIFICATION TO STAKEHOLDER

This section is optional. We will send a formal announcement of your accreditation achievement to up to two stakeholders.

ACCREDITATION DECISION NOTIFICATION TO STAKEHOLDER #1

Title

First Name

Middle Initial

Last Name

Suffix (Jr., Sr., etc.)

Credentials

Work Telephone

Extension

E-mail Address

Job Title

Organization Name

Mailing Address

Suite Number, Floor, Department, or OTHER

City

Country

State/Province/Territory

OTHER State/Province/District (outside North America Only)

Zip/Postal Code

County

ACCREDITATION DECISION NOTIFICATION TO STAKEHOLDER #2

Title

First Name

Middle Initial

Last Name

Suffix (Jr., Sr., etc.)

Credentials

Work Telephone

Extension

E-mail Address

Job Title

Organization Name

Mailing Address

Suite Number, Floor, Department, or OTHER

City

Country

State/Province/Territory

OTHER State/Province/District (outside North America Only)

Zip/Postal Code

County

SURVEY ACCESSIBILITY

What files or documents do you keep or have available in electronic format?

Check all that apply.	File/Document	Description
☑	Financial records	All
☐	Outcomes system	
☐	Personnel records	
☑	Policies and procedures	Employee policy and procedure manual
☐	Records of persons served	
☐	Other	

Will an interpreter be needed for the survey team to conduct this survey?

☐ Yes
☑ No

If yes, specify language(s).

In what primary language are your organization documents written?

☑ English
☐ French
☐ Spanish
☐ Swedish
☐ Other

If other, specify language.

SURVEY APPLICATION ITEMS

Items identified as required must be submitted.

Do not send items that include protected health information.

ITEM

Item
Budget for programs/services seeking accreditation

Required
☑

Format
☐ Hard Copy
☑ Electronic

Date Received by CARF International

Attachment	Date Added	Type	Size
2018-19 Budget abbr..pdf	3/25/2019	.pdf	207.76 KB

ITEM

Item
Information used to describe programs/services - Std. 2.A.1.

Required
☑

Format
☐ Hard Copy
☐ Electronic

Date Received by CARF International

Attachment	Date Added	Type	Size
Mission of the Fort Smith Children.docx	3/25/2019	.docx	13.97 KB

ITEM

Item
Map(s) with the sites marked

Required
☐

Format
☐ Hard Copy
☐ Electronic

Date Received by CARF International

ITEM

Item
Organization chart

Required
☑

Format
☐ Hard Copy
☑ Electronic

Date Received by CARF International

Attachment	Date Added	Type	Size
CARF Organizational Chart 2019 020519.docx	3/25/2019	.docx	98.14 KB

ITEM

Item
Other Item(s)

Required
☐

Format
☐ Hard Copy
☐ Electronic

Date Received by CARF International

ITEM

Item
Performance analysis - Std. 1.N.1.

Required
☑

Format

☐ Hard Copy

☑ Electronic

Date Received by CARF International

Attachment	Date Added	Type	Size
QUALITY IMPROVEMENT PROCEDURES.docx	3/25/2019	.docx	17.24 KB

INFORMATION FOR EVALUATION

Minimum Qualifications

C. QRTP Trauma-Informed Program Description

The Children's Emergency Shelter (CES) Qualified Residential Treatment Program serves and treats foster youth, referred by the Arkansas Division of Children and Family Services (DCFS), with serious emotional and behavioral problems whose needs cannot be met in any other setting. Our program has been designed to be trauma-informed , strengths and needs-based, resident centered and family focused.

All trauma informed mental health services will be sub-contracted through and provided by Western Arkansas Counseling and Guidance Center (WACGC). All mental health services will be provided to the residents on the premises of the CES.

The CES admits all referrals made by the Arkansas DCFS if beds are available and if admission criteria are met. Referrals and intakes will be accepted 24 hours a day, 7 days a week. Placement shall be contingent upon the results of the client's 30-day QRTP assessment. An intake study/assessment will be completed by the CES within ten days of admission.

Discharge planning begins when a resident is admitted into the QRTP. Discharge is planned and notice provided to DCFS 30 days prior to scheduled discharge so that a sufficient transition plan is in place for the resident. A discharge summary is prepared and submitted to the referring DCFS county office at least ten days prior to the discharge date. The discharge summary contains all required information as stated by DCFS. In cases of discharge due to a resident having to be placed in a psychiatric setting, the CES will accept the resident back into the QRTP, if appropriate.

Due to the patterns of disorders, behaviors, and disruptions of the foster youth who are served, the CES has implemented an evidence-based trauma-informed treatment model which helps engage our foster youth more effectively. The trauma-informed treatment model will offer the potential to improve outcomes for the youth who are placed in our QRTP. Through completed and on-going trauma-informed training, the CES: (1) realizes the widespread impact of trauma and understands potential paths for recovery; (2) recognizes the signs and symptoms of trauma in individual foster youth, families, and staff; (3) integrates knowledge about trauma into policies, procedures, and practices; and (4) seeks to actively resist re-traumatization of foster youth served and staff. The CES staff is trained in and implements principles of Trust Based Relational Interventions (TBRI) and the Crisis Prevention Institute's Non-Violent Crisis Intervention (NCI). Both of these programs recognize the impact of trauma and have a strong focus on: (1) Empowerment of the youth; (2) Choice; (3) Collaboration; (4) Safety; (5) Trustworthiness. All of these areas are attributes and core principles of a trauma-informed organization. The CES staff also completes other trauma-informed training modules on Relias, our on-line training curriculum on a semi-annual basis.

The CES also implements services that are strengths based and needs based. Tailoring services to each of our residents and their families is critical for increasing their safety, permanency, and well-being. The CES staff identifies and draws upon the strengths and needs of our residents and their families. Rather than focusing on deficits, each resident's and family's unique set of strengths are

acknowledged and used in developing case plans, after care plans, and every aspect of daily life at the CES' QRTP.

The CES believes services should be flexible in order to meet each resident's needs in a manner that is best for him/her. CES' philosophy of resident centered care means that we consider the resident as an equal partner in developing plans for his/her care. The resident and his/her family are at the center of decisions, working alongside professionals to obtain the best outcomes. The CES staff case manager completes an individual case plan and a S.N.A.P. (strengths, needs, abilities and preferences) sheet with each resident upon intake. This information is shared with all staff and is used as a means to show compassion and respect and to think about things from the resident's point of view, especially in times of crisis or potential crisis.

The CES recognizes that family engagement and outreach is an important aspect of each resident's treatment and success. The CES facilitates outreach to the resident's family members, including siblings. The method of contact and all known contact information is maintained and documented. In the case of terminated parental rights or documented unsuccessful efforts to contact the parents/guardians, there is an exception to these requirements. In an effort to improve outcomes after discharge, the CES also provides discharge planning and family-based after care support for at least six months, when appropriate.

Western Arkansas Counseling and Guidance Center (WACGC) will provide CES with the ability to provide twenty-four-hour, seven days a week mobile crisis intervention in the home and community setting. The CES will have access to licensed clinical staff, including a registered nurse, at all times. WACGC staff will be contacted when a crisis arises that staff is unable to solve. The desired outcome of requesting mobile crisis intervention will be the de-escalation of the situation, using trauma-informed practices and preventing the resident from being admitted to any psychiatric setting or higher level of care.

All residents, upon intake will be administered a C-SSRS to determine if there is a risk for suicide. If It is deemed so, WACGC will be immediately contacted and will provide all necessary care to ensure the safety and well-being of the resident.

Any time mobile crisis intervention is utilized, DCFS and a CES supervisor will be contacted and notified. A thorough incident report will be completed by CES staff. The incident will be logged into the Critical Incident Log, as required by Licensing, and also sent to the resident's DCFS worker.

BEHAVIORAL HEALTH AGENCY

Arkansas Department of Human Services

Division of Provider Services and Quality Assurance

This certificate acknowledges the completion of the Arkansas State Certification Process

WESTERN ARKANSAS COUNSELING AND GUIDANCE CENTER, INC.
3111 SOUTH 70TH STREET
FORT SMITH, AR 72903

Dates of Certification: 11/01/2018 - 06/30/2020

Vendor Number: 11019
BHA License Number: 020

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