APPENDIX A

**DYRS COMMUNITY SERVICES STAFF SECURE FORMAT FOR PROPOSALS**

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| **Provider Name:**    **Service**: |
| Program/service location: (list City and State): |
| Total program capacity: |
| Gender accepted:  males only  females only  both males and females |
| Ages accepted: Minimum:       Maximum:  Will your program consider exceptions on the age criteria on a case-by-case basis?  yes  no |
| Describe your treatment philosophy and the key components of your treatment program. In addition, please address:   * Are there specific treatment modalities that you believe are particular strengths or weaknesses of your facility? * With what types of clients have you been particularly successful? Unsuccessful? * How do you manage disruptive clients? Aggressive clients? * What kinds of behavior(s) would result in expulsion or premature discharge of youth from your program? |
| Target Population - criteria and eligibility (include minimum Full Scale IQ if applicable): |
| Exclusion criteria: |
| Will your program consider exceptions on any admission criteria on a case-by-case basis?  yes  no  If yes, please specify: |
| Will your program consider youth on psychotropic medications?  yes  no  If yes:  Mental health clinical monitoring of psychotropic medication will be provided directly by certified program staff  Mental health clinical monitoring of psychotropic medication will be provided through an agreement or subcontract with outside individuals or agencies with qualified mental health and substance abuse staff  What are the arrangements for administering medication?  Do you have medical/nursing staff available in the program on a 24 hour basis to manage side‑effects or adverse reactions to medications? If not, please de­scribe how medical support would be provided in such an eventuality.  Enclose a copy of your policies and procedures for medication administration and management. |
| Will your program consider youth with any history of fire play activity?  yes  no  case-by-case  Comments: |
| Describe how you program for transgender youth: |
| Will your program consider youth with a history of inappropriate sexual acting out issues?  yes  no  case-by-case  Comments: |
| Referrals/Admission Requirements: |
| Does your program have the capacity to handle any of the following special populations? (check all that apply)  hearing impaired  visually impaired  physically handicapped  capacity to work with non-English speaking youth and/or families  If yes, languages spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Program’s targeted average length of stay (in days):       to  Minimum Length of Stay Your Program Will Accept (in days): |
| Educational services provided:  directly by the Contractor  through the public school system  through a sub-contract |
| Educational service offerings:  regular education only  both regular and special education  If yes to special education, how does your agency provide administrative oversight of the special education program? |
| Are vocational services offered?  yes  no  If yes, what services? |
| Does your agency have the capacity to maintain the ability to provide 1:1 staff coverage for Staff secure youth requiring hospitalization as part of the program per diem?  yes  no |
| What transportation services are included in your program per diem (check all that apply):  admission only  discharge only  both admission and discharge  home passes  Comments: |
| Family program components (list type, frequency and credential of staff providing family focused services): |

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| Criteria and frequency for home passes: |
| Does your program offer individual counseling?  yes  no  Frequency:       Services offered by:  degreed staff  non-degreed staff  Staff credentials if applicable: |
| Does your program offer group counseling?  yes  no  Frequency:       Services offered by:  degreed staff  non-degreed staff  Staff credentials if applicable:  Types of treatment groups available: |
| Does your program offer family counseling?  yes  no  Frequency:       Services offered by:  degreed staff  non-degreed staff  Staff credentials if applicable: |
| List evidence based practices and training/oversight to insure implementation fidelity: |
| Does your program offer a certified, substance abuse treatment program?  yes  no  If yes, Licensing/certification agency:  If yes:  Substance abuse services will be provided directly by licensed/certified program staff  Describe service offerings:  Substance abuse services will be provided through an agreement or subcontract with outside individuals or agencies with qualified mental health and substance abuse providers  Minimum length of time youth must be enrolled in your program in order to ensure that youth can participate in this program (in days)? |
| Staffing information - List credentials of professional staff: |
| List medical services offered on site (either directly or through contracted services). In addition, note days and hours that on-site medical services are offered : |
| Contact name, address and telephone number of child care licensing agency: |
| What is you State’s minimum direct care staff to student ratios when youth are:  Awake:       Sleeping:  What is your program’s proposal for minimum direct care staff to student ratios when youth are:  Awake:       Sleeping:  Is there awake staff in the sleeping areas of all students at all times?  yes  no  If no, please explain: |
| How many years has your agency been providing staff secure services to delinquent youth?  Please provide a brief history in your Program Description of your agency’s history of providing services to delinquent youth. |
| What is your policy on student restraints or other restrictive procedures (e.g. methodology, frequency of use within your facility, etc.)? |
| Does your agency gather any type of Outcome Performance Measure data? If yes, please summarize content, collection methodology, frequency of data collection, etc.: |
| List other States or jurisdictions that are currently contracting with your agency for comparable services in this proposal: |
| May we contact all of these providers as references for your agency? ?  yes  no  If yes, please list agency contact names, phone numbers and addresses.  If no, please explain: |

**Use additional sheets or attachments as necessary and/or provide detail in attached Program Description.**