

CHILD SERVICES COORDINATOR GRANT PROGRAM

Operations Manual – Fiscal Year 2009



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CHILD SERVICES COORDINATOR GRANT

PROGRAM YEAR

Fiscal Year 2009 begins on July 1, 2008 and ends on June 30, 2009.

PROGRAM INTENT

The goal of Child Services Coordinator Grant (CSCG) is to address the special health care, mental health, and educational needs of homeless children residing in either emergency shelters or transitional housing programs. This will be accomplished by providing funds to help support a Child Services Coordinator(s) who is solely responsible for ensuring the needs of the children are being met.

The Child Services Coordinator (CSC) is responsible for screening children entering a facility. Any child with identified health or mental health needs must be referred to the most appropriate community resource for care and treatment. Each school age child, during the school year, must be enrolled in school. As time permits, CSCs may provide parent education training programs, individual or group sessions for the children or other activities that will help a child adjust to shelter living or enhance efforts to address other identified personal needs.

Agencies receiving CSCG funds must have a comprehensive policy in effect for mandatory reporting of suspected child abuse and neglect. Agencies are strongly encouraged to contact the local department of social services and domestic violence programs for on-going guidance and training on this issue.

ELIGIBLE USE OF FUNDS

Grant funds are to be used to pay salary or wages and any other associated personnel costs for a professional Child Services Coordinator.

These positions must be filled by persons with a bachelor's degree in a human services field or equivalent of professional and educational experience in human services. Agencies are strongly encouraged to require a combination of formal education and work experience directly related to issues of child development and/or working with families living in poverty.

A criminal record and Child Protective Services check must be completed for any CSC.

DESCRIPTION OF REQUIRED SERVICES

For FY 2009 the attached DHCD screening forms should be used. Sites may modify and/or use their own forms upon approval from DHCD. It is understood that some children only stay in shelter one or two nights and it may not be possible to complete all the required forms. Grantees are expected to fulfill the following expectations whenever possible:

- The General Child Intake Form must be filled out on each child entering the program within 24 hours.
- The Physical Health, Mental Health and Educational Screening forms must be completed within four days of intake.
- A separate case file (or section of a family's case file) must be created and maintained on each child admitted into the program and who has stayed longer than four days.
- Based on the results of the screenings, an Individualized Service Plan must be developed with the parent(s) in order to facilitate the coordination of services needed for the child.
- Any actions or activities on behalf of the child must be documented in case notes.
- Grantees are expected to use the DHCD forms unless a written waiver is given by the DHCD Program Administrator.

Agencies providing CSC services in both Emergency Shelter and Transitional Housing Services should develop an internal policy outlining how the CSC position will be used in each program. Quarterly statistical reports should reflect the population of children served.

The following details the required and recommended services of the CSC.

General Child Intake Form (*Form A*)

Required Services

- Screening must be made for all children entering the program within 24 hours
- Basic assessment of children should be made
- CSC processes and services must be outlined with the parent and child (if appropriate) at this time

Recommended Services

- Upon parent request, begin the process of accessing outlined documentation related to the child

Mental Health Services (*Form B*)

Required Services:

- Screening must be made for children, over the age of five, who remain in the program four days or longer
- Referrals must be made if there is a clear indication that the child should be seen by a licensed mental health professional for assessment
- Children under the age of five should be screened if there are clear indications that the child is exhibiting serious emotions or behaviors that are not age appropriate.

Recommended Services:

- Establish contacts with school counseling staff representing area school systems
- Coordinate educational efforts for parents on developmental issues, resiliency factors and parenting issues related to their children
- Arrange participation of children and youth in various support groups
- Establish contacts with community services boards in the region

Physical Health Services (*Form C & D*)

Required Services:

- Screening must be made for children who remain in the program four days and longer

- Referrals should be made for any necessary care or treatment, including but not limited to the provision of required immunizations and inoculations as necessary

Recommended Services:

- Arrange school physicals
- Arrange in-shelter education for basic preventative health practices (nutrition, hand washing, etc.)

Education Services (*Form E&F*)

Required Services:

- Pre-School or School Age Screening form must be made for children who remain in the program four days or longer
- During the school year, coordinate efforts between the shelter, area school(s) and Project HOPE to expedite student enrollment in schools, student evaluation for special services for children when necessary and make arrangements for transportation.
- Facilitate enrollment of homeless preschoolers in programs such as Headstart and Evenstart programs

Recommended Services:

- Organize tutorial and remedial education services within the shelter or with schools and other agencies
- Provide parental awareness programs on children's educational rights and resources
- Provide professional development for educators and other school personnel regarding issues faced by homeless child

Related Services

Required Services:

- Ensure a confidential release and exchange of information form is signed by the parent or legal guardian
- Develop and maintain a comprehensive resource list of children's resources in the community for staff and parents

Recommended Services:

- Initiate community awareness campaigns informing service providers of the issues concerning homeless children
- Provide information on childcare services and transportation

TARGETED OUTCOMES REPORTED TO VIRGINIA DEPARTMENT OF SOCIAL SERVICES

- 30 percent of children in Emergency or Domestic Violence Shelters will receive a Health Assessment.
- 30 percent of children in Emergency of Domestic Violence Shelters, who are over five years old, will receive a Mental Health Assessment.

- 75 percent of children in Transitional Housing Programs will receive a Health Assessment.
- 75 percent of children in Transitional Housing Programs will receive a Mental Health Assessment.

FUNDING ALLOCATIONS

The total available funding allocation for CSCG for FY 09 is \$1,089,375. Agencies are awarded amounts based on the following criteria:

CSCs for Emergency Shelters

- Funding decisions are based on the average number of new children admitted each month during the time period July 1, 2006 – December 31, 2007.
 - Shelters accepting fewer than five children per month on average do not receive funding.
 - Shelters accepting between five and eleven children per month on average receive funding for one half-time position.
 - Shelters accepting between 12 and 17 new children per month on average receive funding for one fulltime position.
 - Shelters accepting between 18 and 23 new children per month on average receive funding for one and one half-time positions.
 - Shelters accepting between 24 and 29 new children per month on average receive funding for two fulltime positions.
 - Shelters accepting over 29 new children per month on average receive two and one half-time positions.
 - No agency will receive funding for more than two and one half-time positions.

CSCs for Transitional Housing

- Funding decisions are based on the average number of children in residence each day during the time period July 1, 2006 – December 31, 2007.
 - Programs averaging fewer than 20 children in residence each month are not funded.
 - Programs averaging between 20 and 45 children in residence each month receive funding for one half-time position.
 - Programs averaging between 46 and 70 children in residence per month receive funding for one full time position.
 - Programs averaging over 70 in residence per month receive funding for one and one half-time positions.
 - No agency will receive funding for more than one and one half-time positions.

GENERAL EXPECTATIONS

- The original Fiscal Year 2009 Grant Agreements must be returned to DHCD by July 31, 2008. Payments will not be released until the agreements are received.
- Child Services Coordinators must be employed and prepared to assume their job responsibilities by July 31, 2008. A grantee may lose their grant award if there is no dedicated staff to fulfill the CSC responsibilities by this date.

- DHCD reserves the right to reduce grant awards for any agency not spending money at an appropriate rate.

REQUESTING FUNDS

Funds are disbursed on a reimbursement basis. The Grantee agrees to adhere to the procedures and schedule outlined regarding reimbursement. The reimbursement schedule is as follows:

Expenditure Period	Request for Reimbursement Submission Date
July 1, 2008 – July 31, 2008 *	August 10, 2008
July 1 or August 1, 2008 – August 31, 2008 *	September 10, 2008
September 1, 2008 – October 31, 2008	November 10, 2008
November 1, 2008 – December 31, 2008	January 10, 2009
January 1, 2009 – February 28, 2009	March 10, 2009
March 1, 2009 – April 30, 2009	May 10, 2009
May 1, 2009 – June 30, 2009 (projected)	May 10, 2009

** Grantees have the option of submitting a reimbursement request for July expenditures by August 10, 2008. If a request is made in August for July expenditures, the September request is to reflect expenditures for only August.*

Please note that a portion of the CSCG grant allocation is TANF funds and a portion of the grant allocation is funds from the State General Fund. These are denoted on your grant agreement. Grantees that have not expended all TANF funds by February 28, 2009 must project TANF expenditures for March and April along with the March 10, 2009 Request for Reimbursement.

Grantees that have not expended the state general fund portion of their allocation by April 30, 2009 must submit projections of customary expenditures for May and June with the May 10, 2009 Request for Reimbursement.

CSG Requests for Reimbursements must be completed on the excel forms provided electronically by DHCD. State and TANF funds must be requested on the same form for expenditure period. Once complete, the form should be printed, signed and mailed to:

Program Administrator
Homeless and Special Needs Housing Unit
Department of Housing and Community Development
501 North Second Street
Richmond, VA 23219-1312

FAXES WILL NOT BE ACCEPTED. ALL REQUESTS FOR REIMBURSEMENTS MUST BE COMPLETED IN EXCEL, SIGNED AND MAILED (TO BE POST MARKED BY THE DATES INDICATED ABOVE)

If your agency is not receiving funds via “electronic transfer”, please sign up for an account as soon as possible. Go to the Virginia Department of Accounts web site:

<http://www.doa.virginia.gov>

On the menu of options on the left hand side of the page click on EDI (Electronic Data Interchange). This link provides instructions to set up an account. Once you have established an account, your funds will be deposited directly into your bank account.

REPORTING

All grantees must submit **Statistical Reports** on a quarterly basis to DHCD. Statistical Reports must be submitted for each of the four quarters in fiscal year 2009, even if CSCG funds are not expended in the quarter. Statistical Reports are **only accepted electronically** to the Housing and Homeless Assistance unit of DHCD (hsnh@dhcd.virginia.gov). Contact the DHCD Program Administrators for additional copies of quarterly reports.

The due dates for quarterly reports are as follows:

- October 10, 2008 (for report period July 1, 2008- September 30, 2008)
- January 10, 2009 (for report period October 1, 2008- December 31, 2008)
- April 10, 2009 (for report period January 1, 2009- March 31, 2009)
- July 10, 2009 (for report period April 1, 2009- June 30, 2009)

Submission of the quarterly reports implies approval from the Executive Director and is considered final. Any changes to quarterly reports must be made by the fifteenth of the month in which the reports are due. DHCD reserves the right to withhold reimbursement payments if the Grantee fails to submit the quarterly reports in accordance with the prescribed schedule. Repeated non-compliance with reporting requirements may result in further grant restrictions.

DHCD is required to submit periodic reports to the Virginia Department of Social Services. Delays in reporting may cause delays in processing TANF payments. Therefore, it is imperative that each grantee submits all reporting information accurately and in a timely manner.

COMMUNICATIONS

A considerable amount of information and program updates are sent to grantees via E-mail. All grantees are expected to have at least one E-mail account through which they can receive these messages. It is strongly encouraged that child services coordinators be allowed to send and receive E-mail messages. Grantees are expected to notify DHCD of any change in the E-mail address.

MONITORING

DHCD staff will monitor use of CSCG funds with a thorough review of all reports and back-up documentation submitted. In addition, DHCD staff may conduct on site reviews of administrative, financial and programmatic components. On site monitoring will be scheduled in advance. When possible, on site CSCG monitoring will be conducted in conjunction with monitoring for the Child Care for Homeless Children Program, State Shelter Grant and the Emergency Shelter Grant.



**Department of Housing and
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CHILD SERVICES COORDINATOR GRANT

General Child Intake Form

This form must be completed by the child's parent with the Child Services Coordinator within the first 24 hours in the program.

Child's Name/Unique Identifier: _____

Parent's Name: _____

Date the family entered the facility: _____

Child's Age: ____ Date of Birth: _____

Siblings also in the facility:

Name _____ age: ____ Name _____ age: ____

Name _____ age: ____ Name _____ age: ____

Name _____ age: ____ Name _____ age: ____

Is the child separated from any sibling? yes no

If yes, please explain:

Is the child separated from any other immediate family member? yes no

If yes, please explain:

Name of last school: _____ Currently enrolled? yes no

Name of last day care or after school program: _____

Form A

If necessary, will you be able to easily obtain the following?

- yes no Birth Certificate
- yes no Social Security Card
- yes no Immunization records
- yes no School Records
- yes no n/a Custody Agreement
- yes no n/a Protective Order

Would you like for the staff to assist you in obtaining any of your child's records? If yes, please describe the help you need.

Is there anything about your child that you think staff should be aware of?

Signatures:

Parent **Date**

CSC **Date**



Mental Health Screening Form For CSCG FY 09

TO BE COMPLETED WITH PARENT/GUARDIAN

DEMOGRAPHIC INFORMATION	
Child's Name or Unique Identifier:	Date of Assessment:
Parent/Guardian:	Completed with:

COUNSELING/THERAPY	
Has your child ever been to a counselor or therapist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child currently in any form of counseling/therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How do you feel about your child's prior or current counseling?	

PERSONALITY	
How would you describe your child since you have entered this program? Check all that apply.	
<input type="checkbox"/> Happy	<input type="checkbox"/> Depressed
<input type="checkbox"/> Very Sad	<input type="checkbox"/> Aggressive
<input type="checkbox"/> Angry	<input type="checkbox"/> Kind/Caring
<input type="checkbox"/> Relieved	<input type="checkbox"/> Curious
<input type="checkbox"/> Confused	<input type="checkbox"/> Frustrated
<input type="checkbox"/> Over-protective	
<input type="checkbox"/> Other: Please Explain:	

Has your child's behavior or personality changed noticeably in the last few months or since the situation that brought your family here?

Has your child exhibited any of the following behaviors in the past six months? Check all that apply.

<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> No appetite
<input type="checkbox"/> Aggressiveness	<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Socially isolating
<input type="checkbox"/> Refuses to follow directions	<input type="checkbox"/> Sexual activity
<input type="checkbox"/> Drug or Alcohol use	<input type="checkbox"/> Over-eating
<input type="checkbox"/> Stealing	<input type="checkbox"/> Fighting
<input type="checkbox"/> Persistent sadness	<input type="checkbox"/> Violence towards animals
<input type="checkbox"/> Frequently interrupts adults	<input type="checkbox"/> Destroys property

Other: Please Explain:

Do you have any specific concerns or want to share information related to your child's mental health?

Signatures:

Parent **Date**

CSC **Date**



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Physical Health Screening Form

This form must be completed by the child's parent with the Child Services Coordinator before the end of the fourth day in the program.

Child's Name/Unique Identifier: _____

Parent's Name/ Unique Identifier : _____

Date the family entered the facility: _____

Today's Date: _____

Insurance Information

Please indicate the type of insurance coverage your child has now.

- Family Access to Medical Insurance Security (FAMIS)
- Children's Health Insurance Program (CHIP)
- Medicaid
- CHAMPUS
- Anthem Blue Cross and Blue Shield
- Other: _____
- My child does not have health insurance
- I would like assistance in obtaining health insurance for my child.

Physician or clinic information

Name of the child's pediatrician: _____

Name of the clinic where the child has received health services:

Approximate date of the child's last doctor visit. _____

Reason:

Approximate date of the child's last physical exam. _____

What prescription medications is the child currently taking?

yes no Does the child have any current health issues that need to be addressed?
If yes, please explain:

yes no Has the child had any serious health issues in the past?
If yes, please explain:

yes no Does the child have any allergies? If yes, please explain:

yes no Are all the child's immunizations up to date?

yes no Are the immunization records easily attainable if needed?

yes no Does the child have any current dental issues that need to be addressed?
If yes, please explain:

yes no Does the child have any current vision problems that need to be addressed?
If yes, please explain:

Are there any other things you would like to share about your child's physical health, or any concerns that we haven't discussed yet?

Signatures:

Parent **Date**

CSC **Date**



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Physical Health Assessment Form

TO BE COMPLETED WITH CHILD (if age 5 or older)

Child's Name/ Unique Identifier:

Age:

How do you feel today? Any aches, pains, injuries, bruises, etc.?

Do you ever have headaches?

When was the last time, if you can remember?

Do you ever get stomachaches?

When was the last time, if you can remember?

When you are sleeping do you have dreams and/or nightmares? Tell me about them.

How do you feel when you wake up? (Prompts: rested, tired, happy, sad)

Do you have any trouble reading the blackboard at school?

Do you ever have trouble hearing your teacher, parent, or friends?

Is there anything else you want to tell me about how you feel?



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Education Screening Form for Young Children (Pre-School)

This form must be completed by the child's parent with the Child Services Coordinator by the end of the fourth day in the program.

Child's Name/ Unique Identifier: _____

Parent's Name/ Unique Identifier: _____

Date the family entered the facility: _____ Date of Assessment: _____

Name of pre-school program where child was most recently enrolled: _____

Location: _____

How long has the child been enrolled? _____

Yes No If transportation can be arranged, would you like for your child to continue attending this program?

If yes, what is the name of the child's teacher? _____

What do you feel are your child's educational strengths?

What assistance do you feel your child needs to perform better in pre-school?

Yes No Do you feel your child demonstrates age appropriate learning and comprehension skills? If no, what are your concerns?

Signatures:

Parent

Date

CSC

Date



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Education Screening Form for School-Aged Children

This form must be completed by the child's parent with the Child Services Coordinator by the end of the fourth day in the program. However, if the family enters the program during the summer when school is not in session; the child is not attending summer school and the plan is for the family to leave the program before the beginning of the fall semester, this form does not need to be completed.

Child's Name/ Unique Identifier: _____

Parent's Name/ Unique Identifier: _____

Date the family entered the facility: _____ **Date of Assessment:** _____

Name of school where child was most recently enrolled: _____

Location: _____

yes no If possible, do you want your child to attend this school while you reside in this program?

yes no Was the child attending school regularly?

How long has your child attended this school? : _____

What do you feel are your child's educational strengths?

What assistance do you feel your child needs to perform better in school?

yes no Has the school staff informed you of any learning or behavior difficulties that your child is having? If yes, please explain:



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yes no Is your child receiving special educational services and have an IEP?
If yes, please explain what special services your child is receiving.

yes no Do you feel your child demonstrates age appropriate learning and comprehension
skills? If no, what are your concerns?

yes no Would you like for us to try and arrange for a tutor or mentor to work directly with your
child here in this program?

yes no Is your child involved in any extra-curricular activity after school?

yes no If yes, would you like for your child to continue in the activity?

Is there any other important information about your child's educational needs that we should know?

Signatures:

Parent **Date**

CSC **Date**