STATE OF ARKANSAS
OFFICE OF PROCUREMENT
ARKANSAS DEPARTMENT OF HUMAN SERVICES
700 Main Street
Little Rock, Arkansas 72203

RESPONSE PACKET
710-19-1025

CAUTION TO VENDOR

Vendor's failure to submit required items and/or information as specified in the *Bid Solicitation Document* **shall** result in disqualification.

SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	The Boy's Shelter, Inc.				
Address:	5904 So. Zero Street				
City:	Fort Smith	State:	AR	Zip Code:	72903
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:	Eddie T. Donovan	Title:	Executive Director
Phone:	479-646-2819	Alternate Phone:	479-769-5624
Email:	boysshelterdirector@gmail.com		

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: [signature] *Use Ink Only.* **Title:** Executive Director

Printed/Typed Name: Eddie T. Donovan **Date:** 4/3/19

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:	The Boy's Shelter, Inc.	**Date:**	4/3/19
Authorized Signature:	[signature]	**Title:**	Executive Director
Print/Type Name:	Eddie T. Donovan		

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:	The Boy's Shelter, Inc.	**Date:**	4/3/19
Authorized Signature:	[signature]	**Title:**	Executive Director
Print/Type Name:	Eddie T. Donovan		

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:	The Boy's Shelter, Inc.	**Date:**	4/3/19
Authorized Signature:	[signature]	**Title:**	Executive Director
Print/Type Name:	Eddie T. Donovan		

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 & Guidance Center	3111 So. 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:	The Boy's Shelter, Inc.	**Date:**	4/3/19
Authorized Signature:	[signature]	**Title:**	Executive Director
Print/Type Name:	Eddie T. Donovan		

Attachment G. has the Minimum Qualification Checklist that your RESPONSE will be checked against. You must submit all information requested so that information can be verified. Failure to submit the requested information may cause your response to be disqualified. ***Do not complete and return this form with your response***. It is for information only.

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

4/3/19
Date

The Boy's Shelter, Inc.
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

4/3/19

Date

The Boy's Shelter, Inc.

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: [X] Yes [ ] No
SUBCONTRACTOR NAME: The Boy's Shelter, Inc.

IS THIS FOR: [ ] Goods? [X] Services? [ ] Both?

TAXPAYER ID NAME: 51-0172844

YOUR LAST NAME: Donovan **FIRST NAME:** Eddie **M.I.:** T.

ADDRESS: 5904 So. Zero Street

CITY: Fort Smith **STATE:** AR **ZIP CODE:** 72903 **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							

[X] **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								
Constitutional Officer								
State Board or Commission Member								
State Employee								

[X] **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 [signature] Title Executive Director Date 4/3/19

Vendor Contact Person Eddie T. Donovan Title Executive Director Phone No. 479-646-2819

Agency use only

Agency Number_____ Agency Name_____ Agency Contact Person_____ Contact Phone No._____ Contract or Grant No._____

Policy Name : Equal Employment Opportunity   Policy Section: Pg 4

Policy: Employee Handbook   Date Written/Revised: 1978-2016

Policy

It has been and will continue to be the policy of The Boys Shelter, Inc. to be fair and impartial in all its relations with its employees and applicants for employment and to make all employment-related decisions without regards to race, religion, color, national origin, age, sex, disability, or any other categories protected by federal, state, or local law. This policy applies to recruitment, hiring, training, promotion, and all other personnel actions and conditions of employment such as compensation, benefits, layoffs and reinstatements, training, tuition, tuition assistance, and disciplinary measures. Decisions regarding employment and promotion will be based solely only upon valid job-related factors. Any employee with questions or concerns about any type of discrimination in the workplace are encouraged to bring these issues to the attention of the Executive Director or any member of the board of directors. Employees can raise concerns and make reports without fear of reprisal. Anyone found to be engaging in any type of unlawful discrimination will be subject to disciplinary action, up to and including termination of employment.

Procedures

The Fort Smith Boys Shelter does not discriminate on the basis of race, religion, national origin, gender, age, marital status, or physical or mental handicap. Hires and promotes on the basis of individuals qualification and performance. If at anytime an employee believes that he or she has been a victim of discrimination or any form of sexual harassment they may follow the policy and procedures of the Employee Handbook on page 4. Any employee with questions or concerns about any type of discrimination in the workplace are encouraged to bring these issues to the attention of the Executive Director or any member of the board of directors. Employees can raise concerns and make reports without fear of reprisal. Anyone found to be engaging in any type of unlawful discrimination will be subject to disciplinary action, up to and including termination of employment.

INFORMATION FOR EVALUATION

Minimum Qualifications

A. RESIDENTIAL CHILD WELFARE AGENCY LICENSE: See Attached

B. ACCREDITATION APPLICATION AND PAYMENT: See Attached

C. QRTP TRAUMA-INFORMED PROGRAM DESCRIPTION:

The Boys Shelter Qualified Residential Treatment Program serves and treats foster children referred by the Arkansas Division of Children and Family Services, with serious emotional and behavioral problems whose needs cannot be met in any other setting. The Boys Shelter 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 subcontracted through and provided by Western Arkansas Counseling and Guidance Center in Fort Smith, AR. All mental health services will be provided to the residents on the premises of The Boys Shelter.

The Boys Shelter 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 clients 30-day QRTP assessment. An intake evaluation will be completed by the Boys Shelter within 10 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 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 higher level of care setting (psychiatric) the Boys Shelter will accept the resident back into the QRTP , if appropriate.

Due to patterns of disorders, behaviors, and disruptions of the foster children who are served, the Boys Shelter has the implementation an evidence-based trauma-informed treatment model which helps engage our foster children more effectively. The trauma-informed treatment model will offer the potential to improve outcomes for the children who are placed in out QRTP. Through completed and ongoing trauma-informed training, the Boys Shelter:

- Realizes the widespread impact of trauma and understands paths for recovery
- Recognizes the signs and symptoms of trauma in individual children, families and staff.
- Integrates knowledge and trauma into policies, procedures and practices
- Seeks to actively resist retraumatization of foster children served and staff

The Boys Shelter staff is trained in (HWC) Handle with Care. This program which supports children exposed to trauma and violence through improved communication and collaboration between law enforcement, schools/child care agencies and mental health providers, and connects families, schools and communities to mental health services. This program has a focus on:

- Empowerment of the children served
- Choice
- Collaborations
- Safety
- Trustworthiness

All of these areas are attributes and core principles of a trauma-informed organization. The Boys Shelter staff also completes other trauma-informed training modules on Relias, our online curriculum on a semi-annual basis.

The Boys Shelter also implements services that are strength and needs based. Tailoring services to each of our resident and their families is critical for increasing their safety, permanency, and well being. The Boys Shelter staff identifies and draws upon the strengths and needs of our resident and their families. Rather than focus on deficits, each residents and families unique set of strengths are acknowledge and used developing case plans, after care plans, and every aspect of daily life while at the Boys Shelter's QRTP.

The Boys Shelter believes services should be flexible in order to meet each resident's needs in a manner that is best form him. The Boys Shelter's philosophy of resident centered care means that we consider the resident as an equal partner in developing plans for his care. The resident and his family are at the center of decisions, working alongside professionals to obtain the best outcomes. The Boys Shelter staff Case Manager completes an individual case pan and a S.N.A.P which include (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 residents point of view, especially in times of crisis or potential crisis.

The Boys Shelter recognizes that family engagement and outreach is an important aspect of each resident's treatment and success.The Boys Shelter facilities outreach to the resident's family member, 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 Boys Shelter also provides discharge planning and family-based after care support for at least six months, when appropriate.

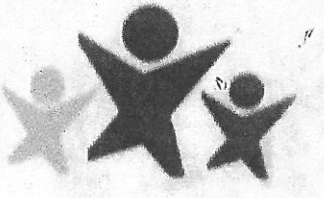
Western Arkansas Counseling and Guidance Center in Fort Smith, AR will provide the Boys Shelter to provide 24/7, 7 days a week mobile crisis intervention in the home and community setting. The Boys Shelter will have access to licensed clinical staff, including a registered nurse at all times. Western Arkansas Counseling and Guidance will be contracted 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, Western Arkansas Counseling and Guidance 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 Boys Shelter supervisor will be contacted and notified. A thorough incident report will be completed by Boys Shelter staff. The incident will be logged into the Critical Incident Log, as required by Licensing, and also sent to the resident's DCFS worker.

D. BEHAVIORAL HEALTH AGENCY LICENSE OF SUBCONTRACTOR: ATTACHED

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

The Boy's Shelter, Inc.
Owner

The Boy's Shelter
Agency

5904 SOUTH ZERO ST

FORT SMITH, AR 72903

Is hereby issued Residential license #: 214

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

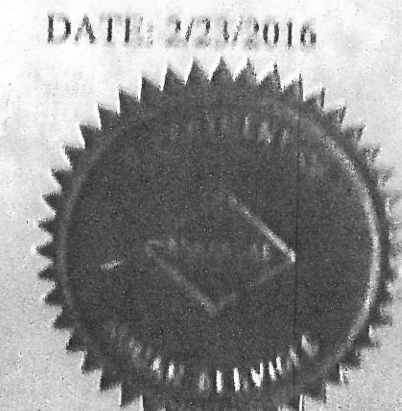
RESIDENTIAL CHILD CARE FACILITY FOR 12 CHILDREN AGES 13 TO 18

THIS IS A REGULAR LICENSE WITH AN EFFECTIVE DATE OF 02/24/1998 AND WILL REMAIN IN EFFECT UNLESS THERE IS A STATUS CHANGE.

In Witness whereof

Chairman, Child Welfare Agency Review Board

DATE: 2/23/2016



Mental Health Services Contract

The Boys' Shelter recognizes the need for education, early intervention, and prevention services in regards to Qualified Residential Treatment Program (hereafter QRTP) residents (residents hereafter) mental/emotional health issues. As such, The Boys' Shelter wishes to contract for such services to be provided during normal hours of operation or otherwise specified. Western Arkansas Counseling and Guidance Center (WACGC hereafter) is an entity desiring to contract to provide such services.

The following is an agreement by and between WACGC and The Boys' Shelter in regards to services to be provided. This agreement will be effective for a period of 3 years from the date the agreement is executed.

CONTRACTUAL RESPONSIBILITIES OF WACGC:

I. WACGC will provide services through licensed Mental Health Professionals and supplemental interventions through Qualified Behavioral Health Paraprofessionals, who are supervised by the licensed therapist. WACGC also provides a wide array of behavioral health services to include medication evaluation and management by medical providers such as psychiatrists, physicians, and Advanced Practice Registered Nurses. WACGC will verify appropriate current documentation of licensures for therapists that will be providing services to residents and their families. Documentation to be submitted will include, at a minimum, current state license/certification (showing expiration date), background check, board certifications (if applicable), proof of accreditation and a copy of current driver's license. Current QBHP certification for QBHPs will also be verified before services are to be provided.

II. WACGC will provide services of individual, group, and/or family therapy, MHP/QBHP interventions, collateral, crisis, and stabilization interventions as needed at the discretion of the mental health provider, with goals and objectives to be determined by resident needs, staff availability, and mental health provider's expertise/knowledge. Services will also be provided based on the individual needs of the referred resident. Psychiatric Diagnostic evaluations and medication management are also available as deemed medically necessary.

3111 South 70th Street
P.O. Box 11818
Fort Smith, Arkansas 72917

Ph. 479-452-6650
Fax 479-452-5847
www.wacgc.org

III. WACGC will provide well-coordinated services to include but not limited to the following: management of PCP referrals, consultation, advocacy, and collaboration with community providers and resources based on resident and family/guardian needs.

IV. WACGC will provide both therapy and case management services as needed and agreed upon by WACGC and Maggie House. Services will be provided during normal hours of operation of The Boys' Shelter, and other times as treatment for the resident deems necessary or in a school setting. Specific days and times for each therapist/case manager will be mutually agreed upon and will be subject to change as needed. Both parties agree that there will be occasional instances of scheduling changes to accommodate normal occurrences (e.g. vacation leave, sick leave, continuing education, school testing, et cetera), which shall not require a written agreement but shall require appropriate communication with resident/family and appointments will be rescheduled in a timely manner.

V. WACGC will not be responsible for transporting residents.

VI. WACGC will agree to sign and follow confidentiality agreements, which shall include compliance with the privacy provisions of HIPPA with The Boys' Shelter

VII. All communication, written or verbal, shall comply with all applicable state and federal laws regarding confidentiality.

VIII. With appropriate parental/guardian consent and resident consent when required, WACGC will communicate with other providers of services in order to facilitate continuity of care for the residents participating in the services provided by WACGC and The Boys' Shelter.

IX. WACGC acknowledges and understands that its mental health providers are mandated reporters as defined by the Arkansas Child Maltreatment Act and as such will report all suspected forms of child maltreatment. Failure to do so may constitute grounds for immediate termination of WACGC Services Contract with The Boys' Shelter. In the instance a child maltreatment incident is reported, WACGC will also make a direct report to The Boys' Shelter program when a report is made; specifically if/when a report involves The Boys' Shelter personnel in a prompt and timely manner.

X. WACGC will offer periodic in-service education for The Boys' Shelter. In-service guidelines will be as follows, meeting the QRTP staff.

XI. WACGC and its employees shall meet the standards of The Boys' Shelter, exhibiting suitability for the QRTP setting to work as MHPs / QBHPs. If The Boys' Shelter determines WACGC staff is not in the best interest of the residents services may be discontinued upon notification.

XII. WACGC employees shall identify themselves during their work at The Boys' Shelter with The Boys' Shelter identification badges that include Contractor and employee name. These badges will be provided by WACGC. WACGC employees shall be required to sign-in and out on a designated form, developed by The Boys' Shelter when entering a QRTP.

CONTRACTUAL RESPONSIBILITIES OF THE BOYS' SHELTER:

I. The Boys' Shelter will provide reasonable access to the facilities for the mental health providers in a space, allowing total confidentiality, assigned by the building staff. The mental health provider will follow applicable The Boys' Shelter policies regarding access and codes of conduct.

II. The Boys' Shelter will make modifications to the program as necessary throughout the service contract period.

GENERAL PROVISIONS:

I. The Boys' Shelter may terminate this agreement with a 30 day written notice to WACGC if it determines a breach of contract or if it can no longer commit within its mission and resources. If WACGC can no longer commit to this agreement, the agency may terminate this agreement with a 30 day written notice. At any time and without written notice, The Boys' Shelter may terminate this agreement for cause, which shall include, but are not limited to, instances of:

(i) an intentional l act of fraud, embezzlement, theft or any other material violation of law that occurs during or in the course this agreement;

(ii) intentional damage to The Boys' Shelter property;

(iii) disclosure of residents' confidential information to unauthorized recipients;

(iv) intentional breach of The Boys' Shelter policies;

(v) the willful and continued failure to substantially perform.-m the duties under this agreement for company (other than as a result of incapacity due to physical or mental illness); or

(vi) willful conduct by WACGC that is demonstrably and materially injurious to The Boys' Shelter, monetarily or otherwise.

II. Any additional modifications to this contract must be mutually agreed upon and shall be made in writing.

III. Medicaid, private insurance, and direct pay will be billed by WACGC consistently with third party payer, regulatory, and WACGC fee agreement and payment policies.

IV. The parties acknowledge that WACGC will not refuse services to a Medicaid eligible recipient in a QRTP setting unless we do not have the program to adequately treat the mental health needs of that resident. In this case, either WACGC or The Boys' Shelter is not restricted from referring any resident for services to another provider. However, when a referral is made to WACGC, the Medicaid regulations for Comprehensive Assessment and Treatment Plan requirements must be met. WACGC will set up an admission interview when the child has a Primary Care Physician (PCP) referral in order that a Prior Authorization may be obtained.

V. Services will be provided in the QRTP at WACGC and community by WACGC Mental Health Professionals and Mental Health Paraprofessionals as deemed necessary by WACGC team members.

By signing below, both WACGC and The Boys' Shelter agree to the above contract explained in pages 1-5. Any changes or modifications to this contract must be agreed upon in writing.

The Guidance Center

Over 40 years of Quality Behavioral Healthcare

Western Arkansas Counseling and Guidance Center

CEO for WACGC, Rusti Holwick

3-15-19
Date

The Boys' Shelter

CEO/or Designee

3-15-19
Date

BEHAVIORAL HEALTH AGENCY

Arkansas Department of Human Services

Division of Provider Services and Quality Assurance

This certi icate acknowledges the completion of the Arkansas State Certification Process

WESTE RN 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

Sherri Proffer, RN
Assistant Director Community Services Licensure and Certification
Division of Provider Services and Quality Assurance

Please mail payment to:
P.O. Box 674401
Dallas, TX 75267-4401, USA

All other communication to:
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

INVOICE

Invoice #	245688
Customer ID	311217
Project/Survey #	118861
InvoiceDate	11/20/2018
Balance Due	Upon Receipt

BILL TO:	SHIP TO:
Boy's Shelter, Inc. 5904 S Zero Street Fort Smith, AR 72903	

PAGE 1

CUSTOMER P.O./ORDER #	PAYMENT TYPE	CUSTOMER SERVICE UNIT
online		CYS

DESCRIPTION	QUANTITY	UNITS	PRICE	EXTENDED PRICE
5020.41 Application Fee - CYS	1.000	EACH	995.00	995.00

11.26.2018 ck 2179 -995.00
Balance Due **0.00**

FAST, SECURE CREDIT CARD PAYMENT
Visit www.carf.org/catalog
Then click Pay Invoice on the left side of the storefront.

CARF reserves the right to change the survey time frame if the survey fee is not paid by the due date. If you have any questions, please contact us at (888) 281-6531 ext. 7130 or email us at bookstore@carf.org.

Sales Total	995.00
Paid	0.00
TOTAL DUE USD $	995.00

Items purchased from CARF are refundable/exchangeable within 90 days of purchase as long as they are unused/undamaged. Shipping cost on returned/exchanged items is non-refundable.

Survey Application

ORGANIZATION INFORMATION

ORGANIZATION TO BE SURVEYED

Field	Value
Organization/Unit Name	Boy's Shelter, Inc.
Acronym	
Federal Tax Identification Number	51-0172844
Organization Website (Example: www.carf.org)	WWW.fsboyshome.org
Telephone (Example: 520-325-1044)	479-646-2819
Fax (Example: 520-318-1129)	479-646-2917
Street Address (no P.O. Box)	5904 S Zero 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	72903
County	Sebastian

ORGANIZATION CHARACTERISTICS

Total annual operating revenue for the organization being surveyed	Annual operating revenue for the programs seeking accreditation	Fiscal Year End
346,238	346,238	12/31

Select all locales or communities served that apply.

Check all that apply.	Locale	Description
☐	Metropolitan	
☐	Rural	
☐	Urban	
☑	Multiple Counties	Multiple Counties in Arkansas
☐	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
- ☐ Publicly traded
- ☑ Private, not for profit
- ☐ Sole Proprietor
- ☐ Private, for profit
- ☐ 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	☑	☐	Department of Human 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	☑	☐	United Way

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

Field	Value
Title	Mr.
First Name	Eddie
Middle Initial	
Last Name	Donovan
Suffix (Jr., Sr., etc.)	
Credentials	B.A.
Work Telephone	479-646-2819
Extension	
E-mail Address	boysshelterdirector@gmail.com
Job Title	Executive Director
Organization Name	Fort Smith Boys
Mailing Address	616 Garrison Ave
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	72903
County	Sebastian

FUNDING/REFERRAL Reference #2

Field	Value
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	

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
/Ir.	Eddie	

Last Name	Suffix (Jr., Sr., etc.)	Credentials
Donovan		B.A.

Job Title	E-mail Address	
Executive Director	Boysshelterdirector@gmail.com	

Work Telephone	Extension	Fax
479-646-2819		479-646-2917

☐ 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

3oy's Shelter, Inc.

Street Address (no P.O. Box)	Suite Number, Floor, Department, or OTHER	City
5904 S Zero Street		Fort Smith

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

Zip/Postal Code	County
72903	Sebastian

ACCREDITATION LIAISON

CONTACT INFORMATION

☐ Same as Survey Key Contact

Title	First Name	Middle Initial
Mr.	Eddie	T
Last Name	**Suffix (Jr., Sr., etc.)**	**Credentials**
Donovan		B.A.
Job Title	**E-mail Address**	
Executive Director	boysshelterdirector@gmail.com	
Work Telephone	**Extension**	**Fax**
479-646-2819		479-646-2917

☑ 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

Boy's Shelter, Inc.

Street Address (no P.O. Box)	Suite Number, Floor, Department, or OTHER	City
5904 S Zero Street		Fort Smith
Country	**State/Province/Territory**	**OTHER State/Province/District (outside North America Only)**
US	AR	
Zip/Postal Code	**County**	
72903	Sebastian	

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**
		479-769-5624
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

7.00

Actual number of direct-service personnel

Employees

8

Contracted Personnel

0

Volunteers

0

Total Direct-Service Personnel

8

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

30

Race/Ethnicity	Number of Persons Served	Other Race/Ethnicity Description
African American/Black	3	
Asian	0	
White	22	
First Nation/Aboriginal Canadian	0	
Hispanic/Latino (Ethnicity)	3	
Native (American or Alaskan)	2	
Native Hawaiian or Other Pacific Islander	0	
Other(s), specify	0	

Gender	Number of Persons Served
Female	0
Male	30
Unknown Gender	0

Age	Number of Persons Served	Other Age Description
0-5 (Children)	0	
06-17 (Adolescent)	30	
18-40 (Adult)	0	
41-65 (Adult)	0	
66-85 (Adult)	0	
86+ (Adult)	0	
Other Age Group	0	
Unknown Age Group	0	

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 ervices, 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	30	
Mental Disorders	20	
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	2	

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

We are a 12 bed boys home, however, during a calendar year we might have up to 30 boys based on a higher level of care need, doption, additional placement for the Department of Human Services.

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

2018 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

5/1/2019

Time Frame End Date

9/30/2019

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."

We need accreditation by October 1st of 2019.

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

☑ Yes
☐ No

Saturday hours of operation

24/7

CONFLICTS OF INTEREST

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

☐ Yes
☑ 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
☑ 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)

☑ Yes
☐ No
☐ N/A

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

☐ Yes
☑ 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
☑ No
☐ N/A

If yes, please list the geographical areas.

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

☐ Yes
☑ No

If yes, please list names.

Are there any other potential conflicts of interest to avoid?

☐ Yes
☑ 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: La Quinta Inn

Street Address: 6700 Boston St

City: Fort Smith

State/Province/Territory: AR

Zip/Postal Code: 72903

Telephone: (479) 484-0303

Fax:

Distance to Survey Headquarters: 5 Miles

Other Notes/Instruction:

HOTEL

☐ **Preferred**

Hotel Name: Fairfield Inn

Street Address: 7601 Phoenix Ave,

City: Fort Smith

State/Province/Territory: AR

Zip/Postal Code: 72903

Telephone: (479) 755-3111

Fax:

Distance to Survey Headquarters: 3.5 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 in Fort Smith Arkansas	1.1 Miles	

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

o 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
2018 Child and Youth Services	Group Home Care - 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

30

Number of locations where this program is provided

1

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

7.00

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

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
Boy's Shelter, Inc.	5904 S Zero 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: Boy's Shelter, Inc.

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

Street Address (no P.O. Box): 5904 S Zero 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: 72903

County: Sebastian

Telephone: 479-646-2819

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.

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: 7.00

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 Care - 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	
☐	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	Department of Human Services	

Other Licensing and Reviews

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	
☐	Outcomes system	
☑	Personnel records	
☑	Policies and procedures	
☑	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

ITEM

Item

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

Required

☑

Format

☑ Hard Copy

☐ Electronic

Date Received by CARF International

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

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

SURVEY APPLICATION AGREEMENT

This survey application agreement ("Agreement") is made and entered into by the undersigned ("Provider") as of the date of execution et forth below ("Effective Date").

A. CARF International ("CARF") is an Arizona, USA, nonprofit corporation engaged in the business of conducting accreditation surveys and rendering accreditation decisions for providers of human services;

B. Provider is in the business of providing human services to the persons it serves; and

C. Provider desires for CARF to conduct an accreditation survey and render an accreditation decision with respect to some or all of its human services programs.

In consideration of the foregoing and the terms and conditions contained herein, Provider hereby acknowledges and agrees as follows:

1.0 Programs
CARF and Provider shall mutually agree on the program or programs for which CARF will conduct an accreditation survey and render an accreditation decision ("Program").

2.0 Conduct of Survey
Provider shall permit CARF to conduct an accreditation survey of the Program in accordance with CARF's policies and procedures in effect from time to time.

3.0 Scope of Decision
The accreditation decision rendered by CARF shall apply only to the Program, as it exists at the time actually surveyed by CARF. Accreditation shall not apply to any programs or sites not actually surveyed by CARF without CARF's prior written approval. Similarly, the accreditation decision shall only apply to the Program while it is owned and operated by Provider, unless approved by CARF in writing.

4.0 Standards Manual
The CARF standards manual in effect for the Program's program type(s) on the date the accreditation survey is conducted or scheduled to be conducted shall be the manual applicable to the accreditation process, the accreditation survey, and the resulting ccreditation decision. Once the accreditation decision is rendered, continuation of accreditation shall be governed by CARF's ccreditation conditions, applicable standards, and policies and procedures in effect from time to time. Provider shall be responsible for timely payment to CARF of all fees referenced in the applicable standards manual in such amounts as may be current from time to time; provided, that CARF will accept payment on Provider's behalf from a third party.

5.0 Ongoing Performance
During the term of this Agreement, Provider and/or the Program, as appropriate, shall satisfy all CARF accreditation conditions, substantially conform with the applicable CARF standards, and comply with all CARF policies and procedures, as are in effect from time to time, and shall comply with all applicable legal requirements. Any failure to perform the obligations of this section or any other section of this Agreement, as determined in CARF's sole discretion, may result in the denial or modification of accreditation, up to and including termination of accreditation.

6.0 Release of Information
Provider shall provide to CARF, and obtain any authorizations necessary for CARF to review, any and all information deemed necessary, in CARF's sole discretion, to determine satisfaction of CARF accreditation conditions, conformance with applicable CARF standards, and compliance with CARF policies and procedures, as are in effect from time to time, including but not limited to confidential organizational and consumer records. Provider shall also make consenting consumers available for interview, as requested by CARF.

7.0 Truth of Information
CARF shall rely upon the truth and accuracy of all information provided to it by Provider. Accordingly, Provider hereby warrants and represents that all of its employees, representatives, and agents who have provided or will provide information to CARF have been duly instructed to provide only accurate, truthful, and complete information and that, to the best of Provider's knowledge and belief, such instructions have and will be followed, and all information provided to CARF is and will be accurate, truthful, and complete.

8.0 Disclosure to CARF
All third parties are hereby expressly authorized to disclose and deliver to CARF such information and documents as CARF may request, in its sole discretion, in connection with the accreditation survey, accreditation decision, and continuation/termination of accreditation. This Agreement shall constitute evidence of authorization to release information and documents to CARF.

.0 Disclosure by CARF
ARF is hereby expressly authorized to make public, at its sole discretion, information related to Provider and the Program, to the extent not confidential or protected by law.

10.0 Indemnification
Provider shall indemnify, defend, and hold harmless CARF and its directors, officers, employees, agents, and representatives from and with respect to any and all claims, costs, demands, charges, lawsuits, and liabilities of any kind whatsoever which may be made or asserted against it, them, or any of them, at any time by any person, firm, agency, or entity, resulting from or relating, directly or indirectly, to the accreditation survey, accreditation decision, or continuation/termination of accreditation.

11.0 Limitation of Liability

11.1 Exclusive Remedy
The review and appeal processes set forth in CARF's policies and procedures in effect from time to time shall be Provider's sole and exclusive remedy with respect to all of its accreditation surveys, accreditation decisions, and continuation/termination of accreditation, and Provider hereby expressly waives any and all other rights and remedies.

11.2 Waiver
Provider hereby expressly waives and releases CARF and its directors, officers, employees, agents, and representatives from any and all claims, costs, demands, charges, lawsuits, damages, and liabilities of any kind whatsoever which may arise from or relate to, directly or indirectly, all of its accreditation surveys, accreditation decisions, or continuation/termination of accreditation.

11.3 No Warranties
CARF makes no, and hereby disclaims, any and all representations and warranties, whether written or oral, express or implied, as to all of the Program's accreditation surveys, accreditation decisions, or continuation/termination of accreditation.

12.0 Term
This Agreement shall be effective as of the Effective Date and shall terminate upon the earlier of: (a) the expiration of nine (9) months from the Effective Date without an accreditation survey being scheduled; (b) the date of issuance by CARF of (i) a Nonaccreditation decision, or (ii) the affirmation of a Nonaccreditation decision when Provider elects to pursue an appeal, whichever is later; (c) expiration of accreditation term; or (d) termination of accreditation by CARF. Sections 9.0, 10.0, 11.1, 11.2, 11.3, 13.0 and 14.0 hereof shall survive termination of this Agreement.

13.0 HIPAA
If Provider is located in the United States and is a covered entity under HIPAA, the parties hereby agree to be bound by the terms of the CARF Business Associate Addendum located at http://www.carf.org/BAA, which agreement, as amended by CARF from time to time, is incorporated herein by reference (unless Provider is a Veterans Health Administration entity).

14.0 Miscellaneous
(a) This Agreement shall be binding upon Provider and its successors and assigns; provided, however, that Provider may not assign any rights nor delegate any duties under this Agreement without the prior written consent of CARF. (b) This Agreement may not be amended, modified, or terminated orally, and no amendment, modification, termination, or attempted waiver shall be valid unless in writing signed by CARF. (c) Should any provision of this Agreement be held invalid, illegal, or unenforceable by a tribunal of competent jurisdiction for any reason whatsoever, the remaining terms and provisions of this Agreement shall not be affected and shall continue to be valid and enforceable to the fullest extent permitted by law. (d) The failure at any time by CARF to require strict performance of any provision of this Agreement shall not constitute a waiver by CARF of such provision, even if CARF knows of the nature of the performance and fails to object to it. (e) Nothing expressed or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than CARF and Provider and their successors and permitted assigns, any rights, remedies, obligations, or liabilities whatsoever. (f) This Agreement shall be governed by the substantive law of the State of Arizona, USA. Except as otherwise provided herein, any and all disputes, claims, or controversies arising between CARF and Provider with respect to the performance, terms and conditions, or subject matter of this Agreement shall be resolved by final and binding arbitration conducted in Tucson, Arizona, USA, by a single arbitrator under the auspices and in accordance with the commercial arbitration rules of the American Arbitration Association. The single arbitrator is specifically authorized and instructed to award reasonable attorney's fees and costs to the prevailing party. (g) The submitting representative of Provider has the legal right, power, and authority to enter this Agreement and bind Provider to all of the terms and provisions hereof.

By checking the box below, you represent that you are authorized to bind the organization and agree to all of the terms and conditions contained in the survey application agreement above.

On behalf of the organization, I agree to all of the terms and conditions of the survey application agreement.
☐

Online survey application submitted by