Meeting Planning Reference Guide

Purpose: Why are you meeting: (you may have several purposes.)

Desired Outcome: What do you want to walk away with: What is the "product" of the meeting: (It's okay to list several desired outcomes.)

Is a meeting really necessary? Can the desired outcome be achieved through different means (phone call, conference call, written communication, speaking with individuals)?

Who should attend? Have you considered people who:

- can help implement the decision?
- challenge the decision?
- actually do the work?
- are customers (both internal and external)?
- have authority with resources?
- are the decision makers?
- are affected by the decision?

Agenda:

What items will be on the agenda?

What are the desired outcomes for each agenda item? The person responsible? Time allotted?

What preparation is required of the participants? What materials will be needed?

Logistics:

What are the beginning and ending times of the meeting?

What is the date of the meeting? Location?

What are your audio-visual needs? Does the location have this equipment?

Language:

How will you handle two or more languages?

Prior to the meeting:

1. Reserve the meeting room and needed audio-visual equipment.

2. Arrange for refreshments, if necessary.

3. Send the agenda to the meeting participants one week prior to the meeting. (Encourage input/feedback.)

4. Prepare flipcharts of the purpose, desired outcome, agenda, ground rules (titled paper to help build the ground rules with the team), action steps (formatted and ready to use during the meeting), and titled "issues bin" or "parking lot."

Opening the meeting:

1. Warm ups/Ice breakers, if appropriate

2. Review and reach agreement on the purpose and desired outcome.

3. Review and reach agreement on the agenda.

4. Review and reach agreement on the ground rules, including the roles of recorder and timekeeper. (ROLES & RULES)
   *Special Note: Remember OARR's
   - Outcomes
   - Agenda
   - Roles
   - Rules

Facilitating the meeting:

- Encourage participation
- Use visuals and materials effectively
- Deal with disruptive behavior appropriately
- Keep group content and activities focused on the outcomes

Concluding the meeting:

1. Review and clarify the action items.

2. Review and clarify the issue bin (or "parking lot.")

3. Decide on what portion of the group memory will be distributed, who should receive it, by what date. Reach agreement on who will distribute the memory and action plan.

After the Close:

Get feedback on the effectiveness of the meeting.

Meeting Organizer

Meeting Date

Meeting Title

Reason for Meeting

Goal of Meeting

Place

MUST ATTEND	NOTIFIED	MUST ATTEND	NOTIFIED

SHOULD ATTEND	NOTIFIED	SHOULD ATTEND	NOTIFIED

MIGHT ATTEND	NOTIFIED	MIGHT ATTEND	NOTIFIED

Agenda

TOPIC	PRESENTER

The Anytown Community Collaborative

Invites you to attend

A Public Meeting

All community members are invited
Wednesday, April 23rd, 7:00 pm
Anytown Community Center
234 Main Street

Topics to be discussed include:

Working with Youth Issues in the Community

Healthy Start Grant

Anytown High School Students

The Sheriff's Department in our Community

Refreshments Provided by:
Anytown Middle School Parents

MEETING TITLE AGENDA

Monday, May 15th - 8:00 a.m.

Overall meeting description and objective for the day. Brief and concise statement followed by outlined topics, speakers, and time line.

TIME	TOPIC	SPEAKER
8:00-8:30	Coffee and Danish	
8:30-9:45	Agenda Topic	Mr. Agenda Speaker
9:45-10:30	Agenda Topic #2	Mr. Agenda Speaker
10:30-10:45	Break	
10:45-12:30	Agenda Topic #4	Ms. Agenda Speaker
12:30-1:30	Lunch Break	
1:30-2:30	Topic #5	Speaker
2:30-3:30	Re-cap and Wrap up	President/CEO

PLANNING ACTIVITIES TIMELINE

		QTR 1			QTR 2			QTR 3			QTR 4		
TASK (GOAL)	**RESPONSIBLE PERSON(S)**	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Sample Meeting Minutes

Anytown Community Collaborative
Town Meeting
April 23, 2000
MEETING MINUTES

In Attendance:
(list of attendees)

Meeting Called to order at 7:00 p.m. by *(name of facilitator)*

1. Agenda item #1.
   Notes on discussion.

2. Agenda item #2
   Notes on discussion.

3. Agenda item #3.
   Notes on discussion.

4. Agenda item #4.
   Notes on discussion.

Meeting adjourned at 9:00 p.m.

Next meeting:
May 21, 2000
Anytown Community Center
234 Main Street

Community COLLABORATIVE
Member Composition Worksheet

Questions a collaborative might ask itself before looking for new members:

1. What talents do we need? (e.g. people with specific expertise in fund-raising, cultural issues, construction, etc.)

2. What do we expect? (Spell it out -- time, financial obligations, meeting attendance, committee work, etc.)

3. Where are we going?

4. Why are we doing this?

Questions prospective collaborative members might ask themselves and the collaborative before making a commitment to serve:

1. What is expected of me?

2. What is the organization's purpose? The collaborative's purpose? Do I believe in it?

3. What am I going to get out of this?

4. Is this the challenge I'm looking for?

5. Do I have the time?

6. Do I have the expertise?

7. Am I comfortable with this group?

An effective collaborative builds support for the community's mission, provides continuity for purpose and policy, and enlists the collective wisdom of carefully selected members to bring a community perspective to issues at hand.

Each community collaborative member brings unique knowledge, insight, skills and personal contacts. By working together a synergism takes effect. Separate ideas blend together to build a whole greater than the parts. To ensure that collaborative membership is balanced and representative of the community, utilize the attached "Collaborative Composition Analysis" worksheet.

Collaborative Composition Analysis Worksheet

Collaborative member

Sex	***Age***	***Ethnic representation***
Female	Over 65	Caucasian
Male	51-65	Native American
	36-50	Black
	21-35	Hispanic
	16-21	Asian
		Other
Group representation	***Area(s) of expertise***	***Relationships***
Business	Public relations	Trusted by community members
Public agencies (law enforcement, social service agencies, health, economic development, etc.)	Strategic planning	Access to policy makers or people with expertise &/or resources
Interested residents (youth & adult)	Fund raising/resource mapping	Access to community groups
Schools	Service provision & program development	
Community-based organizations (churches, service clubs, non-profit organizations, etc.)	Leadership/community mobilization	
Local interest groups (citizen patrol, neighborhood association, etc.)	Policy making & problem solving	
	Measuring results	
	Bilingual	
	Activity/meeting planning, organizing, & facilitating	

Community Collaborative
Planning Worksheet

Why us - why now?

1. Who are we?

2. How are we structured and governed?

3. Why do we exist? What's our mission/purpose and vision/desired state?

4. Where are we now? What are our community's and collaborative's strengths, challenges and priority concerns?

5. Where do we want to be? Which issues of concern can we reasonably impact?

6. How do we get there? What are the obstacles to our community's and/or collaborative's ability to impact and/or resolve identified issues of concern? What are the plans and strategies we'll need to utilize to achieve the priority results?

7. How long will it take? What are reasonable time frames for addressing and achieving our priority results?

8. What will we need to be successful? Do committees need to be formed? If so, what types of talents, resources, and/or expertise will the members need? Should we seek technical assistance? Don't be afraid to look outside your community for assistance and support. Chances are other communities have faced and resolved similar issues.

9. How will we know if we are successful? Which methods should we use to measure progress toward achieving our priority results?

10. How will we communicate our struggles and success with community members, partners, and policy makers?

What products must we develop?

1. Communication pathway. How will collaborative and community members, service providers, policy makers, and partners communicate (e.g. meeting minutes, town meetings, newsletters, etc.)?

2. Collaborative structure and foundation. Define roles. Who will chair/convene meetings? Who will create agendas and record minutes? Who will continually outreach to community members? When and where will meetings regularly occur?

3. Summary of resources. What talents and resources are indigenous or available to our community? What types of technical assistance do we need?

4. If a case management system is planned, develop a work flow design. Case management systems are working successfully in several Kern communities. Consider modifying an existing model as opposed to duplicating design processes and "reinventing the wheel."

Date completed:_____
Date re-evaluated: _____
Date re-evaluated: _____
Date re-evaluated: _____

Anytown Community Collaborative 234 Main Street Anytown, CA 93652 312-888-9900

PRESS RELEASE

For Immediate Release

For more information contact:
Name, Title
000.000.0000

Name, Title
000.000.0000

TYPE HEADLINE HERE

Type sub-headline here

Your City, State, September 17, 2001 -- Begin text of press release here.

*Note:

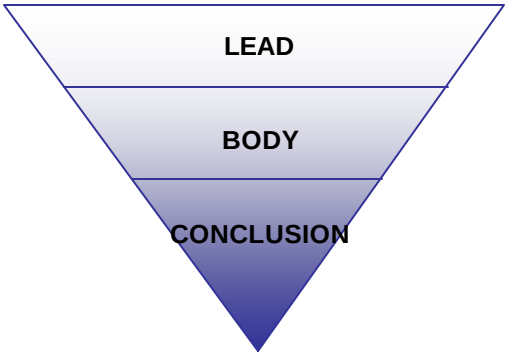
Press releases should be written in news style, with the most important or interesting information in the lead, or first paragraph, and less important information following. This is known as the inverted pyramid style of writing. The press release lead should be concise, interesting and informative to appeal to an editor.

Example of inverted pyramid style of writing in a press release:

LEAD: Often 35 words of less and emphasizes who, shat, where, when, why and how. Try to summarize in one sentence the most interesting aspect of the story to lead off your press release.

BODY: Supports the lead with additional facts in descending order of importance. Weaves in quotes as facts are presented.

CONCLUSION: Often a phone number to call for more information or a quote that sums up the event.



Anytown Community Collaborative

Working togethe ke Anytown a sa nurturing environ r families and childre

For more information, please call John Smith, Facilitating Coordinator at the Anytown Community Center at 888-9900, or any of the Family Advocates listed in this brochure.

FOLD

Sample Brochure

Mission:

The Anytown Community Collaborative is a group of people who are working together to make Anytown a safe and nurturing environment for families and children.

Goals:

- Reduce violence and make neighborhoods safer
- Improve community appearance and image
- Strengthen families

Collaborative Activities:

- Provide recreational and educational activities for youth
- Organize neighborhood cleanup days
- Encourage agencies to provide needed services for families and children
- Help families access services through an integrated case management system
- Provide support and linkages to resources with the assistance of the Family Advocates
- Support and enforce the regulations of the "Crime Free Zone"

Members:

Community residents, parents, youth, concerned citizens, health and social services personnel, school teachers and counselors, law enforcement, personnel, county and city representatives, community-based organizations, and business and property owners. Anyone interested in working with others to improve the quality of life in Anytown is invited to join.

FOLD

Do you or your family need information or help with:

- Case Management Services
- Counseling Services/Information
- English/G.E.D. Classes
- Medical/Dental Care
- Clothing and/or Food
- Substance Abuse
- Domestic/Family Violence
- Other

ACC Family Advocate Service Team:

Family Advocates are community members employed by schools and agencies to help link families with services to address some of their concerns and needs. They work with families who are referred by teachers, counselors, agency representatives, or from self referrals. They meet the family, do an assessment of the family's needs, and work with the family to develop a plan to address its needs.

ACC Case Management Family Advocate Services Team:

- Irma Gomez
- Renee Monsibais
- Rosa Mil
- Lucille Tso
- Emily Jimenez
- Patricia Rodriguez
- Linda Taylor
- Anna Valdivia

Anytown Community Collaborative
Family Resource Center
Neighborhood Survey

The Anytown Community Collaborative is working to establish a Family Resource Center in this community. The Collaborative will provide a variety of services at the Anytown Community Center. This survey will allow the collaborative to provide the services that community members want and need.

The following statements pertain to common needs within every neighborhood. The answers you give should be based on your personal understanding of children and families within your neighborhood. The information you and others provide will assist the collaborative to plan for better services for our neighborhood.

A. Please check the box for the response you feel best fits your opinion of the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
1. There are few services in my neighborhood for families who want and need them.					
2. Our neighborhood lacks employment opportunities and options.					
3. Job training held on a regular basis, here in this neighborhood, would help solve the unemployment problems.					
4. If good, low-cost child care were available in this neighborhood, fewer people would be on welfare.					
5. Physical abuse and neglect of children is a big problem in my neighborhood.					
6. I see children, on a daily basis, who are unkempt, dirty and/or smelling of urine.					
7. Many children in my neighborhood go to school or out to play in clothes that are not the right size or are not right for the weather.					
8. I see many children going hungry on a daily basis.					
9. Non-English speaking members of our neighborhood would probably take advantage of language classes if they were offered in the neighborhood.					
10. Very few people take advantage of the medical services here in the neighborhood.					
11. There are not enough mental health services available in our neighborhood.					
12. There is not adequate housing available in my neighborhood.					
13. There is not good dental care available in our neighborhood.					
14. Alcohol and other drug use is a serious problem in our neighborhood.					
15. Community service agencies should offer more services at the school sites in our neighborhood.					
16. Providing more services in our neighborhood will only keep people on welfare.					

B. Of the following, which would you say is the single most common problem you see among children in the neighborhood?
(circle one answer only)

1. Hunger
2. Lack of clothing
3. Unkempt appearance / body odor
4. Physical abuse
5. Sleepiness / lack of energy
6. Anger / rage
7. Other: _____

C. If you could choose one service you would like to see in our neighborhood, what would it be?

D: Other comments:

_____
_____
_____
_____

E. Optional information

Your age group (circle one) 18-25 26-35 36-45 46-65 65 or over

Ethnicity _____

Number of people in your home: Adults _____ Children_____

Thank you for completing this important survey!

Anytown Elementary School -Parent Survey

1. A DESCRIPTION OF YOUR FAMILY

a. How many children do you have in this school?

b. How many children do you have in other schools?

c. How many adults live in your home?

d. How many years have you lived in Anytown?

e. How many years have you lived in this neighborhood?

f. How many times have you moved in the past three years?

g. Does your child receive:

_____Free Lunch _____Reduced Price Lunch

h. What is your family's ethnic group?

2. TAKING CARE OF YOUR FAMILY'S NEEDS AND PROBLEMS

a. Please circle the three things about your family that help most to solve problems:

1. Communication	4. Problem solving	7. Listening
2. Discipline	5. Time together	8. Family stability
3. Religion	6. Counseling	9. Patience and understanding

b. When you have needs or problems that are too difficult to take care of within your family, who do you go to for help? Please circle the two numbers that are the best place for you to get help.

1. Friends	4. Your children's school
2. Relatives	5. Agencies or organizations
3. Church	

c. Please circle one of the following about trying to get help from schools, agencies or organizations.

1. I have tried to get help
2. I haven't needed help
3. I have not tried to get help

d. If you did try to get help from schools, agencies or organizations, please circle the three numbers that best describe how any of these things were a problem in receiving help:

1. Not eligible for services	5. Transportation
2. Waiting list	6. Child Care
3. Not enough money or insurance	7. Paperwork
4. Didn't know where to go	

3. THE KINDS OF HELP YOU WOULD LIKE TO HAVE

a. Reducing child's emotional or behavioral problems.

b. Improving family relationships.

c. Increasing parenting skills.

d. Dealing with child abuse.

e. Dealing with spousal abuse.
f. Decreasing drug or alcohol abuse.
g. Helping children with school work.
h. Improving child's school performance.
i. Getting more involved in school.
j. Improving adult's education.
k. Preparing young child for school.
l. Improving adult's English.
m. Finding more/better child care.
n. Getting a job / job training.
o. Finding better housing.
p. Getting financial assistance / aid.
q. Increasing children's after school / weekend activities.
r. Providing adequate food and clothing.
s. Improving transportation.
t. Getting legal assistance.
u. Reducing neighborhood crime, violence or gangs.
v. Getting regular health care.
w. Getting regular dental care.
x. Getting vision, speech and hearing tests.
y. Learning how to prevent medical problems.

4. WITH WHAT SUPPORT AGENCIES ARE YOU INVOLVED? PLEASE GIVE THE NAME OF THE WORKER FOR EACH AGENCY CHECKED.

✓	AGENCY	NAME OF WORKER
	Dependents / Wards of the Court	
	WIC	
	Food Stamps	
	AFDC (Welfare)	
	Foster Care	
	CPS (Child Protective Services)	
	Adoptions	
	Reunification	
	At risk of battered families	
	Social Security Income (SSI)	
	California Children's Services	
	Public Health Department	
	Immunization Clinics	
	CHDP (Child Health & Disability Program)	
	Community Connection for Child Care	

5. WOULD IT BE HELPFUL TO HAVE YOUR WORKER AT ANYTOWN COMMUNITY CENTER ON A PART TIME BASIS?

_____Yes _____No

Thank you for completing this important survey. Please return it to the school by September 15, 2000.

SURVEY ON NEIGHBORHOOD PARTNERSHIP/HEALTHY START AWARENESS

The Neighborhood Partnership/Healthy Start Evaluation Team wants to know how aware you are about the work/services being provided in this neighborhood. We will use these findings to plan future work/services for families. This survey takes about three minutes to complete and it is completely confidential. Thank you for your participation.

PART 1

1. Do you see children and families from this neighborhood in need?

   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

2. Can you name three (3) services available to them? If no, go to #3.
   (1)_____
   (2)_____
   (3)_____

3. Do you see more parent involvement in either the school or in the neighborhood than you used to?

   ☐ None ☐ Rarely ☐ Not Sure ☐ Some ☐ A Lot

4. Have you ever heard of Neighborhood Partnership or Healthy Start before today?

   ☐ Never ☐ At least once ☐ 2-3 Times ☐ A Lot of Times

PART 2

1. Your Gender (check one)

   ☐ Male ☐ Female

2. How do you define your ethnicity? (check one)

   ☐ White/Caucasian ☐ Black/African-American ☐ Hispanic/Latino ☐ American Indian

   ☐ Asian/Pacific Islander (please specify) _____

   ☐ Other (please specify) _____

3. Your Occupation_____

4. Do you live in this neighborhood?

   ☐ Yes ☐ No

5. How long have you been involved with this school?_____

6. Are you:

   ☐ Parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Thank you for taking the time to answer these questions.

Date: _____ School:_____

FOCUS GROUP/KEY INFORMANT INTERVIEW PROTOCOL

Note to facilitator: Introduce yourself and the purpose of the focus group or key informant interview. Explain that the interview will be taped to ensure accuracy; however, all results of the interview will be reported anonymously.

1. Please give your name and your occupation.

   Please describe your involvement with the Neighborhood Partnership/Healthy Start, including how long you've been involved in the project.

2. One of the original goals of the Kern County Network for Children was to see the Neighborhood Partnership and Healthy Start projects as a catalyst for change in the way we do business. Thinking back over the past few years, what would you say has changed in this community as a result of NP/HS? Please be specific and give examples.

3. a. Another goal of NP is to improve quality of life by supporting the development of healthy communities and families. If you consider the phrase "healthy community", what comes to mind? What is a healthy community?

   b. Keeping in mind your definition of what constitutes a healthy community, please think for a moment about this community. On a scale of 1 to 10, with 10 being optimally healthy, what ranking would you give this community? Why?

   c. What indicators, if any, suggest that this community has gotten healthier over the past few years?

4. a. When Neighborhood Partnership and Healthy Start first came into being, it was assumed that targeted case management and community involvement would be the keys to promoting a healthier community. Would you agree of disagree with this philosophy?

   b. What does targeted case management look like in this community? (Please describe what you know about how targeted case management operates in this community) What are the strengths and weaknesses of targeted case management as it exists in this community?

   c. What does community involvement look like in this community? What are the strengths and drawbacks of community involvement in this community? How has the level of community involvement changed in the past few years… or has it? (Please give concrete examples.)

5. What didn't I ask that I should have asked?

PURPOSE OF FOCUS GROUP QUESTIONS

I. Community Residents

A. Services

1. Greatest problems, needs of families in this community.

2. Knowledge and use of available services addressing community priority needs (substance use, gang and domestic violence, and graffiti). Do residents know what services are available? Are residents utilizing current services?

3. Barriers to existing services. (e.g.: perception of costs for services, do residents feel that they can afford services?

4. Residents' perception of usefulness or benefits of services. Do residents perceive that these services will benefit them or their family. Do residents think that knowledge of these services will improve their well being and that of the community? Would they like to know more about these types of services?

5. Likelihood that residents will use services. What would increase likelihood that residents will use services? What would make them feel comfortable at facilities or with service providers? What are convenient times and locations?

B. Activities

6. Youth activities. What youth activities, or programs, would parents and youth like to see offered?

7. Adult and family activities. What adult and family activities, or programs, would adults like to see offered?

C. Community Involvement

8. Residents' willingness to become involved in community development process. Are residents willing to become involved in this community? Are they willing to become involved in a group to help bring about changes in the community? What are they willing to do?

9. Perception of capability to affect change. Do residents believe that they, along with others, can make a difference in their community?

II. Activities

A. Parents

1. Knowledge of existing youth activities.

2. Are children currently involved in school or extra-curricular activities?

3. Barriers to existing activities.

4. What youth activities would parents like to see offered in the community?

5. What adult and family activities would adults like to see offered in the community?

6. What are the best times and locations to hold these activities? Do parents or youth have easy access to some means of transportation?

7. Are parents willing and able to help with these activities? If yes, how would they participate? What are they willing to do?

8. Are parents able and willing to pay something in order to participate in youth or adult activities? How much are they willing and able to pay?

B. Youth

1. Knowledge of existing youth activities.

2. Are youth currently involved in school or extra curricular activities?

3. Barriers to existing activities.

4. What specific youth activities would young people like to see offered in the community? What activities are young people most likely to become involved in? How do they like to spend their free time? What is considered fun? What would they like to learn?

5. What are best times and locations to hold these activities? Do parents or youth have easy access to come means of transportation?

6. Are young people willing to become involved in the community? Are they willing to become involved in a group to help bring about changes in the community? What are they willing to do?

7. Do youth believe that by getting involved, they can make a difference in the community?

Example of FOCUS GROUPS SUMMARY STATEMENTS

1. "We need low-income housing. Too many people are living in garages, out by the canals, and in places like that."

2. "Filling out paperwork. For people who may or may not be literate, may or may not speak English, is a problem."

3. "People don't know what's available."

4. "Lack of work is a problem, especially in winter, when the work slows off. Most of the people that live here work out in the fields. They prefer to work in the fields because they do not know how to do anything else. It is easier to get a job in the fields than to get one at the packing sheds. Sometimes it's difficult to get a job because of your age."

5. I heard on the radio about Employers' Training Resource. I think to qualify you just have to be a farmworker, you don't have to live in this community. But it is too far to drive all the way to the city to get the training. I they had it here in the community, it would be easier for everyone that lives here to go."

6. "Transportation is totally inadequate into the city and other areas. If you don't have a car, you're stuck, because the Transit is limited. Getting to work could take hours."

7. "Mental health services are extremely limited in the community; this is especially true for Spanish-speakers."

8. "Create support groups that meet in people's homes to discuss everything form parenting to loneliness to family violence. Use the extended family and the neighborhood to get information out."

9. "Services are offered at all the wrong times."

10. "Many parents come for services with their children because they don't have childcare… I put the Legos and the children on the floor and then I try to counsel the parent. If I don't try to accommodate the children, then I don't have the mom to counsel."

11. "Health care is too limited."

12. "Immunizations."

13. "The clinic offers dental services. If you need some dental work done you have to make your appointment 2-3 months in advance."

14. "The clinic only does physical exams one day a month."

15. "Almost everything is advertised in English, and not in Spanish. That creates unintentional segregation."

16. "The transportation system is so limited; it's the Clinic or the County Hospital or nothing."

17. "A lot of people don't have even the minimum money needed for follow-up. There's a referral, for instance, on a lump in the breast, and they can't afford the follow-up if they don't have medical insurance. And a lot of our patients don't have MediCal."

18. "The 'system' (paperwork, eligibility requirements, etc.) is confusing. Many people don't understand it, and therefore can't access services."

19. “The health center should have some kind of network with the schools so if we have follow-ups to do with a client family, there is somebody that can assist us in reaching the family, in accessing the service.”

20. “Some parents are not aware of the immunization clinic that we have on Fridays.”

21. “Adult school and ESL, offered at appropriate times and locations, so that people can take advantage of them with child care.”

22. “I didn’t even know there were classes available. We need to get the information out.”

23. “Affordable day care. What we have is limited and not affordable.”

24. “After-school child care is needed.’

25. “We have two providers of child care; one is the TAP Center and the other is the state-sponsored preschool. There’s not a lot of child care out there during the day. There are a few families who do child care in their homes, but very, very few. That’s a small resource right now.”

RISK FACTOR RESULTS

1. I think our school is a safe place for students.

	Agree	Disagree
County	78.23%	
Community	56.38%	

2. It's difficult to get marijuana and other illegal drugs at my school.

	Agree	Disagree
County	58.13%	
Community	45.40%	

3. I feel I can turn to the adults I know best for help in solving my problems.

	Agree	Disagree
County	70.18%	
Community	67.10%	

4. The adults I know best don't want me to smoke tobacco.

	Agree	Disagree
County	93.53%	5.20%
Community	72.30%	15.2%

5. The adults I know best don't care if I drink alcohol.

	Agree	Disagree
County	6.55%	87.00%
Community	21.3%	62.33%

6. My parents would be angry if I smoked Marijuana.

	Agree	Disagree
County	93.53%	
Community	84.58%	

7. Most of the adults I know best want me to go to college.

	Agree	Disagree
County	82.75%	
Community	77.00%	

8. My parents want me to do well in school.

	Agree	Disagree
County	96.95%	
Community	91.20%	

9. My friends like school most of the time.

	Agree	Disagree
County	46.55%	
Community	35.13%	

10. I plan to graduate from high school.

	Agree	Disagree
County	94.37%	21.20%
Community	75.40%	15.63%

11. My friends think using alcohol and other drugs is stupid.

	Agree	Disagree
County	82.87%	6.32%
Community	72.50%	15.63%

12. None of my friends smokes cigarettes.

	Agree	Disagree
County	71.60%	
Community	58.60%	

13. None of my friend drink alcohol.

	Agree	Disagree
County	73.08%	
Community	57.13%	

14. I have friends I talk to when I have a problem.

	Agree	Disagree
County	55.6% of 6th grade boys	17.9%
Community	68.1% of 6th grade boys	44.4%

15. Sometimes it is hard to do the right thing when my friends want me to do something wrong.

	Agree	Disagree
County	29.35%	28.02%
Community	59.95%	29.35%

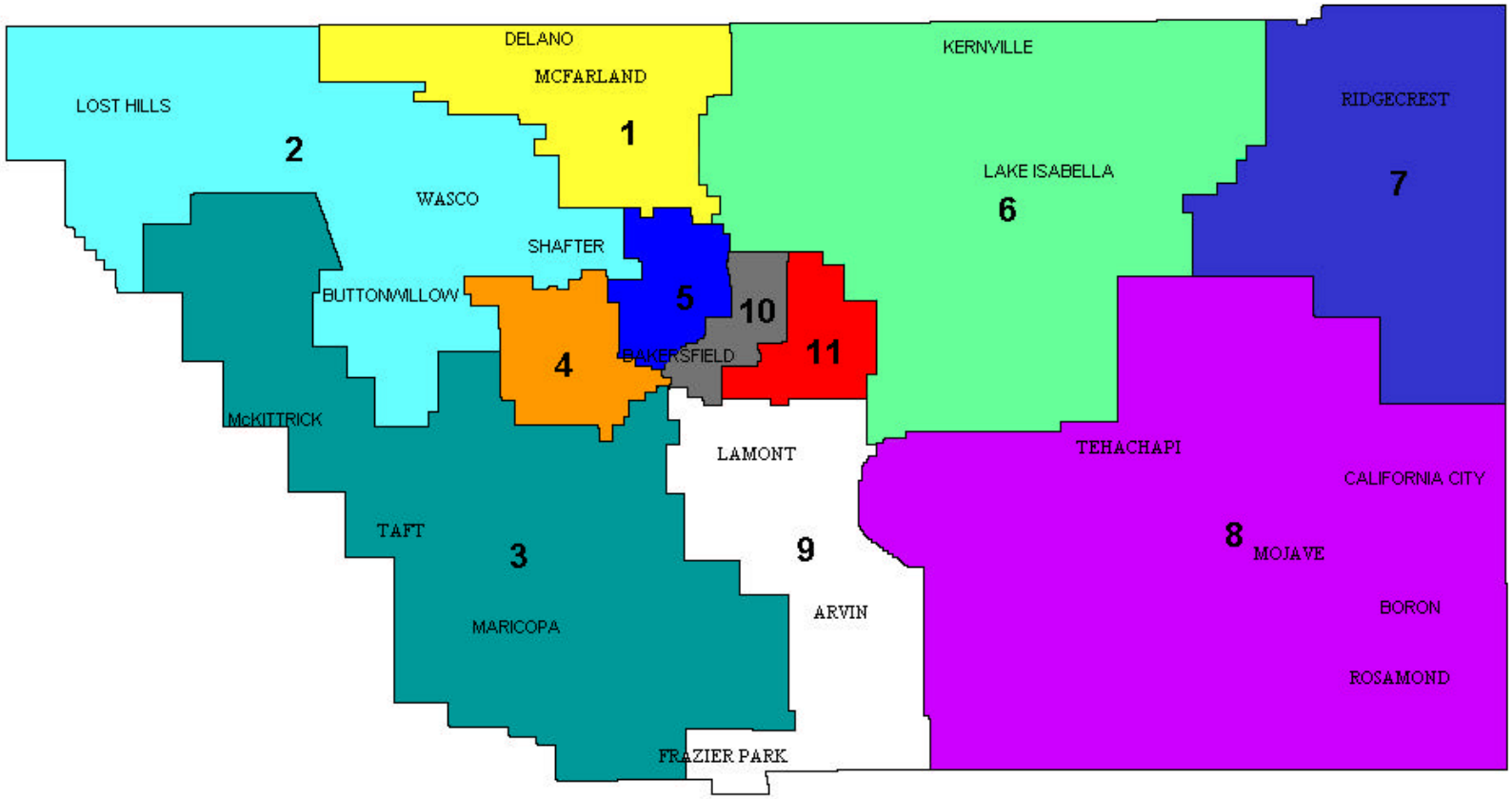
16. I would feel comfortable saying "no" to friends who want me to drink.

	Agree	Disagree
County	82.75%	8.4%
Community	73.70%	8.0%

17. I feel comfortable asking for help in solving my problems.

	Agree	Disagree
County	67.72%	21.13%
Community	57.70%	33.60%

KERN COUNTY MENTAL HEALTH DEPARTMENT
CHILDREN'S SYSTEM OF CARE
GEOGRAPHIC AREAS
2001



Area 1	**Delano, McFarland, Pond**
Area 2	**Shafter, Lost Hills, Butonwillow, Wasco, Semitropic**
Area 3	**Taft, McKittrick, Tupman, Maricopa, Fellows**
Area 4	**West Bakersfield**
Area 5	**North Bakersfield, Glenville, Woody**
Area 6	**Kern Mountain, Lake Isabella, Kernville, Weldon**
Area 7	**Ridgecrest (North Desert)**
Area 8	**Tehachapi, Mojave, Rosamond, Boron, California City (South Desert)**
Area 9	**Arvin, Lamont, Frazier Park**
Area 10	**Central/Southeast Bakersfield**
Area 11	**East Bakersfield**

**Map not to scale. Approximate locations of communities.*

COMMUNITY BASED CHILDREN'S MENTAL HEALTH SERVICES
GEOGRAPHIC AREA CONTACT LIST
2001

GEOGRAPHIC AREA	CITIES/ AREAS	MENTAL HEALTH PROVIDER/ COUNTY DEPARTMENT	CONTACT PERSON	PHONE	FAX	AFTER HRS. CRISES NO.
AREA #1	Delano McFarland Pond	Child Guidance Clinic 1318 High Street Delano, CA 93215	Karen Ice	725-1042	725-1845	725-1042
		Dept. of Human Services	Dennis Yabiku, SW Sharon Osen	631-6137 633-7109		
		Probation Department	Sal Guandique Hector Barragan	868-4722 868-6354	 725-4271	
		Public Health	Rhonda Pflugrad, PHN Karen Martin, PHN Adrienne Smoot, PHN	725-5333 725-5333 725-5333	720-9628 720-9628 720-9628	
AREA #2	Shafter Lost Hills Buttonwillow Wasco Semitropic	Desert Counseling Clinic 1040 7th Street Wasco, CA 93280	Kim Stonelake Adriana Salinas	282-4672 758-4439	758-4463	322-8189
		Dept. of Human Services	Duane Jeffries Sharon Osen	633-7264 633-7109		
		Probation Department	Rito Neri	861-2304	746-3175	
		Public Health (Shafter)	Carol Rush, PHN	746-7562	746-7591	
		Public Health (Wasco)	P.J. Munding, PHN	758-3006	758-3936	
AREA #3	Taft McKittrick Tupman Maricopa Fellows	Memorial Center 401 Finley Drive Taft, CA 93268	Donna Hansen Bruce Hartsell	763-4151 398-1800	763-3775 837-0755	398-1800
		Dept. of Human Services	Stella Perez Sharon Osen	633-7205 633-7109		
		Probation Department	Albert Berlau	868-6390	763-5318	
		Public Health	Beverly Svaleng-Ralston	763-2478	463-8601	

For any questions regarding children's mental health services, please contact Kern County Mental Health Children's System of Care at 868-6721

GEOGRAPHIC AREA	CITIES/ AREAS	MENTAL HEALTH PROVIDER/ COUNTY DEPARTMENT	CONTACT PERSON	PHONE	FAX	AFTER HRS. CRISES NO.
AREA #4	West Bakersfield	Child Guidance Clinic 3611 Stockdale Highway Bakersfield, CA 93309	Karen Page Angela McKinney	327-0933	834-2638	322-1021
		Dept. of Human Services	Heidi Alvarez Gale Meyer	633-7441 631-6437		
		Probation Department	Brenda Moore	868-4171	868-4691	
		Public Health	Area PHN Supervisor	868-0502	868-0218	
AREA #5	North Bakersfield Glenville Woody	Desert Counseling Clinic 1617 30th Street Bakersfield, CA 93301	Kim Stonelake Edward Ohlinger	282-4672 282-4600	282-4679	322-8189
		Dept. of Human Services	Cathy Plank, SW Ann Kobdish, Sup	631-6081 631-6546		
		Probation Department	Voncile Hendricks David Brown	868-4169 868-4100	868-4691 868-4691	
		Public Health	Geri Bennett, PHN Lori Hale, PHN Janet Andrea, PHN	868-5253 868-5252 868-5254	393-3159 393-3159 393-3159	
AREA #6	Kern Mountain Lake Isabella Kernville Weldon	College Health Clinic 2731 Nugget Avenue Lake Isabella, CA 93240 Mailing: P.O. Box 2632	Joni Lanza	(760) 379-3412	(760) 379-5332	1-800-343-4756
		Dept. of Human Services	Dee Rittenhouse Ann Kobdish	633-7190 631-6546		
		Probation Department	Robert Hammond	868-6380	868-6360	
		Public Health	Sharon Vance, PHN	(760) 379-2633	868-6360	
AREA #7	(North Desert) Ridgecrest	College Health Clinic 1400 N. Norma Street, Suite 133 Ridgecrest, CA 93555-2577	Brian Shumway	(760) 499-7406	(760) 499-7479	1-888-343-4756
		Dept. of Human Services	Lisa Frieberg	(760) 499-5223		
		Probation Department	Robert Hammond	868-6380	868-6360	
		Public Health	Margaret Martin, PHN Amy Goriesky, PHN	(760) 375-5157 (760) 375-5157	(760) 375-4210	

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GEOGRAPHIC AREA	CITIES/ AREAS	MENTAL HEALTH PROVIDER/ COUNTY DEPARTMENT	CONTACT PERSON	PHONE	FAX	AFTER HRS. CRISES NO.
AREA #8	(South Desert) Tehachapi Mojave Rosamond Boron California City	College Health Regional Office 20041 Valley Blvd., Suite 1 Tehachapi, CA 93561-6746	Bill Brooks	822-3081	822-3279	
		College Health Clinic 2635 Diamond Blvd. P.O. Box 1359 Rosamond, CA 93560	Janis Cariveau	256-7208	256-7209	1-888-343-4756
		College Health Clinic 113 F Street Tehachapi, CA 93561	Rena Hudson	822-8223	823-9347	1-888-343-4756
		College Health Clinic 16940 Highway 14, Suite E Mojave, CA 93501	Brenna Grass	824-2260	824-9184	1-888-343-4756
		College Health Clinic 8401 California City Blvd. #7 California City, CA 93505	Brenna Grass	(760) 373-2979	(760) 373-2978	1-888-343-4756
		Dept. of Human Services	Debra French, SW	861-2684		
		Probation Department (Tehachapi)	Dave Roberts	868-6380	(760) 375-0121	
		Probation Department (Mojave)	Paul Adams	868-6366	824-9237	
		Public Health (Tehachapi) Public Health (Mojave)	Kay Jefferson, PHN Louise Archuletta, PHN	822-3005 824-4631	822-9765 824-9185	

GEOGRAPHIC AREA	CITIES/ AREAS	MENTAL HEALTH PROVIDER/ COUNTY DEPARTMENT	CONTACT PERSON	PHONE	FAX	AFTER HRS. CRISES NO.
AREA #9	Arvin Lamont Frazier Park	Clinica Sierra Vista 8001 Alicante Way Lamont, CA 93241 Mailing: P.O. Box 457	Tim Speece Steve Schilling, CEO	845-5100	845-5106	845-5100
		Clinica Sierra Vista 3737 Mt. Pinos Way, Suite C&D Frazier Park, CA 93225	Diane Reid	245-0250	245-0252	845-5100
		Dept. of Human Services	Flo Diaz, SW Liz Beath, SW Sharon Osen	631-6359 631-6519 633-7109		
		Probation Department	Eileen Simpson Ramon Jacquez	845-0931 868-5733		
		Public Health (Arvin) (Arvin) (Lamont)	Than Le, PHN Debbie Spencer Lori Falzarano, PHN	854-5411 868-0502 845-3744	854-5909 854-5909 854-6818	
AREA #10	Central/Southeast Bakersfield	Child Guidance Clinic 3628 Stockdale Highway Bakersfield, CA 93309	Kevin Earnest Audrey Hively	322-1021	322-7334	322-1021
		Dept. of Human Services	Barbara Goodlow, SW Gale Meyer	631-6416 631-6437		
		Probation Department	Sharon Green Elaine Wilson	868-4173 868-4170	868-4691 868-4691	
		Public Health	Area PHN Supervisor	868-0502	868-0218	
Area #11	East Bakersfield	Kern County Mental Health 2621 Oswell Street Bakersfield, CA 93306 Mailing: P.O. Box 1000	Alexis Woods	868-6754	868-6752	868-8000
		Dept. of Human Services	Mary Little, SW Terri Kent, SW Mark Kirklin, SUP	631-6934 631-6934 631-6443		
		Probation Department	Elaine Wilson John Gonzales	868-4170 868-4642	868-4691 868-4691	
		Public Health	Area PHN Supervisor	868-0502	868-0218	

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Anytown
Community
Collaborative

Anytown Community Center
234 Main Street
Anytown, CA 93652
312/888-9900
Fax 312/888-9901
jkellogg@iserv.org

STATEMENT OF PHILOSOPHY & MISSION STATEMENT

Our mission is to attain the combined commitment of Anytown families, communities, schools, businesses, public & private entities to help build and sustain healthy families and enrich the lives of children. To accomplish this mission we have adopted the following as fundamental principles to guide us in our work:

1. Personal responsibility and family self-sufficiency are the cornerstones of resilient, stable communities.
2. Families and communities as a whole are better and more efficiently served when we work together.
3. Communities must actively encourage the participation of all residents when addressing issues of common concern.
4. Services are most effective when they address locally identified needs and are provided in settings, which are comfortable and accessible.
5. The effectiveness of programs and services will be determined through progress on benchmarks, which measure childhood well being.

ANYTOWN COMMUNTY COLLABORATIVE ROLES

NEIGHBORHOOD PARTNERHIP VISION STATEMENT:

Neighborhood Partnership is rooted in the vision of the Kern County Network for Children to achieve and maintain a community of healthy families that nurtures, protects and supports all of its people.

GUIDING PRINCIPLES:

The development of the Neighborhood Partnership project has been guided by the following eight principles:

1. Respect the sanctity and dignity of all individuals and families, realizing that people need a sense of self worth and influence.

2. Promote the family as the basic unit of society and make maximum use of family-based support systems.

3. Facilitate the maximum participation of the community-at-large, stakeholders and other consumers, in recognition of our mutual responsibility and shared sense of community.

4. Encourage the belief that a sense of community is dependent on shared civic values and standards of behavior.

5. Advocate the importance of healthy families in maintaining the economic vitality of the community.

6. Emphasize prevention measures as the most cost-effective and promising use of resources.

7. Encourage flexibility and adaptability in all systems.

8. Commit to continuous evaluation and accountability based upon agreed upon outcomes.

Example of KEY ELEMENTS OF A HEALTHY COMMUNITY

The concept of empowerment is central to the development of healthy communities. Successful community projects will encourage individual members to develop a sense that they have (and can create) real options in their lives, and that they can exercise some control in choosing the options. A sense of community empowerment will require planning and concerted effort. Plans must be based on a careful inventory of internal and external resources. Plans will also need to consider what resources or actions may be needed to reverse years or even generations of disempowering attitudes ad negative environments. When individuals become empowered, they, in turn, help their children, families and communities to become empowered. Empowerment, like despair, is contagious.

The following universal elements have been documented, through research, as cornerstones of healthy communities. These elements have formed the backdrop to the Neighborhood Partnership Project.

1. Safe and Affordable Housing:
According to a report by the National Alliance to End Homelessness. 63% of low-income households spend more than 50% of their income on housing. This tremendous income drain, combined with cutbacks in support for housing programs puts many families on the verge of disaster. Many community families are precariously housed and are only one paycheck or one family crisis away from homelessness

2. Employment:
Significant changes continue to occur in the composition of the workforce and in the skills needed in the workplace. At the same time, changes are being made in structure and availability of supported job training and employment initiates for low-income families. Erosion of the two parent family structure and the marked increase in female-headed households has created a new challenge to policymakers. Single parent families headed by women are six times as likely to be poor and the depravation caused is severe and enduring, particularly as it affects children. Poor families are vulnerable to many interconnected problems. Growing up poor often leads to inadequate education and few marketable skills, impaired health and low self-esteem. Children in such circumstances are faced with profound obstacles that may lead to intergenerational dependency.

3. Health Programs:
Poor families have difficulty accessing traditional health services because of financial, bureaucratic, programmatic and individual obstacles. Inflexible scheduling, long waits, inadequate transportation and lack of child care make even routine medical care impossible for many. As a result, families often do not receive adequate acute care, ongoing sservices, essential preventive interventions or necessary health related education

4. Social Networks:
Social supports such as friends, family and community connections are important anchors to individuals experiencing personal and/or economic crisis. Supportive relationships not only ameliorate stress when crisis occurs, they also prevent crisis. For families living in poverty, the absence of networks of support has severe consequences. With adequate support, families in crisis can access emotional help and practical assistance. Four categories of support are readily identified:

- **Informational Supports** - general or specific knowledge or education about solving a problem; reaching an objective or locating a special service.

- **Instrumental Supports** - access to food, shelter, clothing, child care, health care, and financial resource.

- **Emotional Supports** - cultural and artistic expression, companionship, feedback, reassurance of personal worth and expressions of caring.

- **Educational Supports** - life long educational opportunities, designed to meet the needs of a range of community members, including basic general education, parenting skills, living skills, job training and retraining, life enhancement education.

HISTORICAL SUMMARY:
THE KERN COUNTY NETWORK FOR CHILDREN
NEIGHBORHOOD PARTNERSHIP PROJECT

1. The Kern County Board of Supervisors made healthy families a high priority when, in September 1992, they authorized the establishment of the Kern County Network for Children.

2. The Kern County Network for Children concluded that its member agencies, organizations and communities couldn't, working in isolation and within narrowly proscribed circumstances, effectively solve communities' problems or successfully improve family outcomes.

3. The Network for Children brought together the County's senior policy and decision makers, as well as representatives of private enterprise and community based non-profit organizations, to explore possible changes in existing county structure and policy to allow for the development of a public private partnership designed to support and empower communities.

4. Neighborhood Partnership Projects were a call to action aimed at neighborhood communities; an invitation to take ownership of a local planning and empowerment process.

5. Neighborhood Partnership Projects required participating communities to assess their needs; to develop a plan for addressing problems which must include investment by neighborhood residents, and to make a commitment to participate in recording, collecting and analyzing data.

6. Neighborhood Partnership Projects was not an award of money grants, but rather a commitment by government agencies to provide human resources and other materials to the process of planing and implementing local strategies for building safe, healthy communities. The Neighborhood Partnership Projects represent an opportunity for public agencies, private human services providers and local businesses to begin making fundamental changes in the way services are provided.

7. The Neighborhood Partnership Projects are laboratories for learning to rethink traditional roles and to re-deploy resources of public agencies in ways which are more accessible, useful and effective to our target populations.

KERN COUNTY NETWORK FOR CHILDREN
ATTENDANCE SUB-COMMITTEE
John Bernard, Chairperson

STRATEGIES FOR INCREASING THE ATTENDANCE OF STUDENTS IN SCHOOL

GOAL:
SCHOOLS IN KERN COUNTY WILL INCREASE THE ACTUAL STUDENT ATTENDANCE TO 92%

STRATEGY:
INCREASE MEASURES TAKEN AT THE SCHOOL SITE BY DISTRICT STAFF TO SUPPORT STUDENT ATTENDANCE

- Communicate with parents regarding the changes in attendance procedures
- Communicate with students regarding the importance of being in school
- Establish attendance requirements for participation in graduation/extra curricular activities
- Provide in-school suspension
- Provide before and after-school child care
- Conduct attendance contests/rewards for students and their parents
- Maximize use of independent study
- Offer the option of Saturday school for attendance make-ups
- Develop intervention programs to work positively with families whose children are truants

STRATEGY:
INCREASE MEASURES BY COMMUNITY AND BUSINESSES TO SUPPORT STUDENT ATTENDANCE

- Encourage medical and dental providers to not schedule routine appointments during the school day for school-age children, or schedule them late in the afternoon
- Encourage law enforcement to increase their visibility and investigate when observing school-age children who are not in attendance and inquire as to why they are not in school
- Encourage businesses to not serve school-age children during the school day unless they are accompanied by an adult
- Encourage businesses and community i.e., apartment managers, to report school-age children who are not in school via a truancy hotline
- Encourage businesses to contribute "incentive awards" to schools for students who have good attendance
- Encourage judicial officials to insist that parents take responsibility for their child's attendance in school
- Encourage elected officials and parents to deny driver licenses, and driving privileges for teenagers with attendance problems

STRATEGY:
INCREASE AWARENESS ON THE PART OF PARENTS AND COMMUNITY AS TO THE BENEFITS OF ATTENDANCE

- Use media and houses of worship to inform parents and community on the following:
- The importance of monitoring bedtime to ensure that children are rested
- The importance of helping children develop a morning routine so they arrive at school on time ready to start their day
- The importance of being receptive to support from schools to improve children's attendance
- The importance of monitoring study time and providing assistance with homework
- The importance of helping children develop a positive attitude about school, including good study habits, a love of books, an understanding about the importance of school, and respect for those who lead and teach them

- The importance of showing an interest in their child's learning and bridging the gap between home and school to help make school a place where children want to go

IMPLEMENTED PROGRAMS OR EXISTING TOOLS:

- ✓ Gang Risk Intervention Program (GRIP) Grant to prevent gang activity and truancy – Wasco Elementary
- ✓ School Accountability Review Board (SAIW) - Bakersfield City School District
- ✓ Juvenile Probation Officers - Standard School District
- ✓ Healthy Start
- ✓ CalWORKS - Truancy Prevention - Wasco High School District
- ✓ Kern County Substance Abuse Prevention Partnership - KCSOS
- ✓ Kern County Network for Children Truancy Reduction Action Planning Committee
- ✓ Welfare Reform and CalWORKS has had a direct impact on Kern County's children. In total 38,000 families are affected by this program which encompasses school attendance policies for participating families. CalWORKS aid reduction can affect eligible parents whose children do not meet Kern County's 90% attendance standard.
- ✓ Penal Code 272: Contributing to the delinquency of a minor.
- ✓ School Attendance Review Board (SARB)-Bakersfield City School District. Used with K-6 primarily.
- ✓ Truancy citation in Juvenile Traffic Court for poor attendance
- ✓ Saturday school for students with poor attendance
- ✓ Bakersfield City School District's Parent University and parent support groups

Recommendations and Issues:

- ✓ Establish a protocol for what schools need to do first before law enforcement/judicial system gets involved.
- ✓ Need list of tools available distributed to school administrators and law enforcement.
- ✓ The Bakersfield Police Department would like school systems to provide a centralized number to call to see if students are on independent study or otherwise not required to be at school during certain hours.
- ✓ Need to accelerate process with Probation Department, Traffic Court and CalWORKS.
- ✓ Need process where CalWORKS can make referrals to Bakersfield Police Department or Sheriff's Department
- ✓ More schools should have closed campuses so officers can identify truant students

KERN COUNTY NETWORK FOR CHILDREN
CHILD DEATH INDICATORS SUB-COMMITTEE
Karen Cooley, Chairperson

STRATEGIES TO ADDRESS FOUR MAIN AREAS RELATED TO CHILD DEATHS

1. Increased continuity of high-risk infant care to insure that babies make it to their first birthday and beyond.
2. Firearms safety
3. Motor vehicle safety, particularly as it relates to youthful pedestrians, teenage drivers and teens driving under the influence of drugs and alcohol
4. General safety, i.e. reduce the number of deaths caused by adults not paying attention to children's whereabouts or activities

GOAL:
ACCIDENTAL/PREVENTABLE CHILD DEATHS IN KERN COUNTY WILL DECREASE THROUGH A COMBINATION OF COMMUNITY ACTIVITES, EDUCATION, INTERVENTIONS AND COLLABORATIONS.

STRATEGY:
INCREASE THE IDENTIFICATION AND FOLLOW-UP OF HIGH-RISK INFANTS FROM BIRTH ON.

- Work with the local medical community, particularly clinics serving at-risk women, to distribute information to pregnant women, physicians, community clinics and hospitals about AB 38. This legislation gives women and newborns the right to remain hospitalized for 48 hours after a vaginal delivery and up to 4 days after a Cesarean birth. There are newborn medical conditions, some life threatening, that are not detectable until after 24 hours of life. Infants discharged within 12 hours of birth are at risk of these conditions being undetected.
- Advocate with the legislature and other 3rd party payers to provide additional reimbursement for an extra postpartum hospital day for mother and baby.
- Research and/or develop standards for infant discharge that include assessment of high souci-economic risk. Include referral mechanisms to appropriate resources for in-home follow-up, i.e. Child Protective Services, Maternal Child Outreach Programs, Public Health Nursing Family Advocates and Case Managers with community agencies.
- Work with community hospitals to increase the awareness of the need for routine toxicology screening of newborns and develop protocols for said screenings. Explore the use of meconium testing which provides a history of the infant's perinatal drug exposure.
- Join the efforts of the Kern County Network for Children, the medical community and associated groups, agencies and collaboratives to distribute the standards of the American Pediatric Association about toxicology screening and early hospital discharge of newborns. These would address frequency of visits, infant weigh-ins, parent teaching, additional referrals, and assisting with coordination of medical services.
- Encourage the development of coordinated follow-up services between the Neonatal Intensive Care Unit and High Risk Infant Services. Pledge the consultation resources of the Network and appropriate Trustees to this effort. Look to the various case-management systems to incorporate this referral resource into their roster of community services.
- Encourage governmental departments and other agencies to seek grants and other funding to establish and operate home visiting programs for families with children aged 0-5.

IMPLEMENTED:
- ✓ The Kern County Department of Human Services has hired additional Public Health nurses assigned to the positive/toxicology unit, and also additional nurses for the Emergency Response unit for children at high risk.
- ✓ The Kern County Public Health Department has hired two additional Public Health nurses to work with foster children with medical needs.

STRATEGY:
USE COMMUNITY WIDE PREVENTION STRATEGIES, DIRECTED AT PARENTS, ADULTS, YOUTHS AND

COMMUNITY MEMBERS, TO REDUCE FIREARM DEATHS AND INJURIES AMONG CHILDREN.

All firearm deaths or injuries among children, not related to criminal activity, occurred with unsecured weapons. This is true whether the wounds were self-inflicted, accidental or inflicted on others. Since 1994 there have been 26 firearm-related deaths; 15 of these were non-criminally related. Guns ARE a hazard. Possession or firearms increases risk of injury or death to children. The Kern County Network For Children recommends a variety of community based strategies to address this concern.

- Promote a community wide gun safety program, including public service announcements, directed at adults and children.
- Encourage parents to ban the use of toy guns as items of child's play.
- Work within the collaborative structure to develop a curriculum on gun safety for youth.
- Utilize the school based Risk Watch program and after school programs to send a gun safety message to children. Teach children what to do and who to call if they learn about or come upon a firearm. Enlist Boys and Girls Clubs, Friendship House, PAL (Police Action League), Parks and Recreation and the recreation collaborative, Boy and Girl Scouts, and school-based after school programs.
- Teach children the following, simple gun safety message:

IF YOU SEE A GUN...
STOP!
DON'T TOUCH.
LEAVE THE AREA.
TELL AN ADULT.

- Locate or develop a simple and informative pamphlet on gun safety that can be disseminated to parents through parenting classes, schools, collaboratives, community clinics, doctor's offices, WIC, youth programs, and community fairs.
- Develop a list of resources available through libraries, the Internet and the mail that provide information about childhood and adolescent depression, suicide, related erratic behavior and self inflicted gun-shot wounds. In 1996/1997 six out of eight suicides occurred with unsecured firearms.
- Be aware that any and all guns in the home pose a risk to the children who live or visit there.
- Encourage parents and adults to follow these safety strategies:
  1. If guns are kept at home, adults must store and lock them - unloaded - where children cannot reach them.
  2. Talk to their children about the dangers of guns. Let children know they should tell an adult if they see a gun, or see one being used unsafely.
  3. Provide children with positive, supervised activities after school, during vacations and on weekends.
- Take a child's depression seriously. Seek professional help, and make sure the child doesn't have access to a gun.

REMEMBER: NONE OF THESE PROPOSED SOLUTIONS CAN SUBSTITUTE FOR PARENTAL OR ADULT SUPERVISION...

STRATEGY:
DECREASE THE INCIDENCE OF MOTOR VEHICLE AND PEDESTRIAN DEATHS AMONG CHILDREN AND ADOLESCENTS IN KERN COUNTY.

Every year Kern County children die in preventable accidents involving motor vehicles. Although unrestrained passengers are still at high risk for death and serious injury, many children and adolescents die in other-related vehicle accidents that can also be prevented.

- Support and promote existing child passenger restraint and safety seat programs, such as the SAFE Coalition.
- Have the Kern County Network for Children subscribe to the Safe Ride News and distribute information via the Network and collaboratives.

Pedestrian and Other-vehicle Related Accidents:

- Teach parents that preschoolers and schoolchildren (9 years of age and younger) are not developmentally ready to become responsible pedestrians. They cannot judge vehicle speed, distance or danger to protect their own or other children's safety. There should be no independent street crossing below age 7.
- Create community and neighborhood awareness of pedestrian safety issues.
- Distribute pedestrian safety information through parenting classes, in community clinics and physician's offices, health fairs, and other community based venues.
- Encourage community planning in county and city areas that will separate children from traffic. Develop traffic "calming" in high-risk areas; discourage through traffic; enforce neighborhood speed limits; introduce speed bumps or other engineering measures to reduce speeds in high-risk residential areas.
- Reduce children's exposure to traffic. Create vehicle-free play areas, fenced or adequately distanced from roadways.
- Increase child visibility; modify hazards (shrubbery, parking patterns); utilize bright or reflective clothing for children.
- Develop public services messages that clearly instruct parents and adults as to the hazards of everyday vehicle risks, i.e., leaving children unattended in cars; allowing non-licensed youth and adolescents to move, park, back-up or drive vehicles at all; forgetting to check thoroughly or removing children who are in motor vehicle areas.

Adolescent Vehicle Deaths:
While teens are aware that driving while drinking or riding with a driver who has been drinking is dangerous, they do not internalize the reality of the consequences of motor vehicle accidents caused by drunken drivers. Developmentally, it is hard for them to believe that any kind of high-risk behavior could actually cause them or their friends serious harm. The following strategies address this problem.

- Apply for funding through the Department of Alcoholic Beverage Control for "Every 15 Minutes," a high school and community based experiential program that confronts adolescent drunk driving. (Funding was received in early 1999.) The program's name was derived from the fact that in the early 1990's every 15 minutes someone in the U.S. died of an alcohol related accident. The death rate is now one every 30 minutes a still unacceptable figure.
- Identify and select high schools and communities to implement "Every 15 Minutes." This
- two-day program focuses on high school juniors and seniors. It challenges them to think about drinking, driving, personal safety, and the responsibility of making mature decisions and the impact their decisions have on family, friends and many others.
- Support the enforcement of curfews and limitations on the numbers of passengers allowed in adolescent driven vehicles.
- Develop means to combat the flood of pro-alcohol advertising and images aimed at adolescents. These could include prevention programs in schools and after-school programs, public service announcements, and community advertising.

IMPLEMENTED:

✓ The S.A.F.E. Coalition and Seatbelt Youth have continually demonstrated the importance of car seat safety, seatbelt safety, and safe driving through community wide demonstration efforts at local high schools, parks and other public areas. *(See attached information)*

STRATEGY:
REDUCE KERN COUNTY CHILD DEATHS AS A RESULT OF NON-VEHICULAR ACCIDENTS AND INSUFFICIENT SUPERVISION OF CHILDREN.

A significant number of children die each year as a result of adults underestimating the danger or risk in a given situation or not providing adequate supervision. These deaths involve household and body of water drownings, fires, ingestion of toxic substances, accidents due to unsafe play, unsafe play items, unsafe sleeping arrangements, second hand smoke, and shaken baby syndrome. For example virtually all child deaths related to fire have been as a result of unsupervised children playing with matches or lighters. Deaths by drowning have most often been a result of unsupervised children around water sources or non swimmers in high-risk situations, i.e. "swimming" in the Kern River, or not wearing a life vest while boating. The following

strategies and/or actions have been developed to reduce risk.

- Incorporate safety curricula into existing parenting classes, PTA's, Lamaze, WIC and adolescent parent programs, Bakersfield City School Districts "Baby Steps," Headstarts, and state sponsored preschools.
- Utilize local collaboratives, schools and organizations such as the SAFE Coalition to provide safety education and workshops to parents.
- Coordinate selected Network and Collaborative members to locate or develop safety literature and materials, written at the third grade level, for distribution by Public Health Department staff and others who make home visits, i.e. CPSP (Comprehensive Perinatal Services Provider), Healthy Start and Family Advocates.
- Develop and offer safety classes for babysitting teens through youth serving programs.
- Develop and implement a public education/PSA campaign emphasizing age appropriate, parental supervision and use of safety principles, similar to "In the Blink of an Eye."
- Work with the RISK WATCH program to extend safety messages to parents and children at health and community fairs.
- Recruit students to undertake safety video projects.
- Recruit students to develop a web page linking web page safety sites.
- Provide safety checklists to the Family Advocates for distribution to community families.
- Teach children themselves basic safety principles through school and community based programs. These would include "Learn Not to Burn," fire, water and gun safety, 911, poisoning and falls prevention, bike and pedestrian safety, choking, suffocation and strangulation prevention.
- Develop a library with an accompanying guide of video and other safety related materials available for use and/or loan throughout Kern County.
- Encourage the use of smoke detectors and the semi-annual replacement of batteries at the semi-annual time change for Daylight Savings Time.

IMPLEMENTED:

✓ Safety curricula for parenting classes such as Parent and Teacher Associations have been implemented in schools, Lamaze classes at hospitals and clinics and Women Infant and Children programs are already in place.

SIX COMMUNITY MESSAGES:

1. CHILDREN YOUNGER THAN 9 YEARS OLD ARE TOO YOUNG TO BE SAFE PEDESTRIANS. "GO ALONG FOR THE WALK!"

2. TRACK HIGH-RISK BABIES FOR A YEAR.

3. ALL GUNS IN THE HOME ARE A DANGER TO CHILDREN. "UNLOAD 'EM AND LOCK 'EM UP."

4. TAKE A CHILD'S DEPRESSION SERIOUSLY. SEEK PROFESSIONAL HELP AND MAKE SURE THE CHILD DOESN'T HAVE ACCESS TO A GUN.

5. DRINKING AND DRIVING IS A DEADLY COMBINATION. FOR TEENS IT CAN BE THE GAMBLE OF A LIFETIME.

6. "CHILDREN CAN DIE IN THE BLINK OF AN EYE."

KERN COUNTY NETWORK FOR CHILDREN
COLLEGE PREP SUB-COMMITTEE
Tom Jones, Chairperson

STRATEGIES FOR INCREASING THE NUMBER OF HIGH SCHOOL STUDENTS PREPARED FOR COLLEGE

STRATEGY #1:
CHANGE THE CULTURE OF ATTITUDES IN KERN COUNTY TOWARD PREPARATION FOR COLLEGE.

- Change perception of some students, parents and educators that graduating from high school equals preparation for college.
- Change perception of some students and parents that admission to a community college means that a student has completed a high school college preparatory program.
- Change perception of some students, parents and educators that you do not worry about being in a college preparatory curriculum until you reach the tenth grade.
- Change the perception that parents and students don't need to be concerned about the college preparatory placement of the student because school personnel will responsibly arrange that placement.
- Change the perception that most parents don't need information on how their child's school success matches that which will be required for their child to be successful in UCLA, or other University of California campuses.
- Change the perception that because many Kern County students don't want or need to complete a four-year college program, that therefore, it is not important to give them the preparation to make college attendance an attainable option for them after high school graduation.

✓ *Changing the above attitudes will require action by public schools, colleges/ universities, community organizations, and others to provide parents, staff and students with "user-friendly" information about college standards, academic bench-marks for various grade levels, individual student academic strengths and weaknesses, etc.*

✓ *Develop an easily understood "road map to college" that will show parents and students what needs to be learned now (at a given grade level), if the student desires to be prepared for college upon completion of the high school years.*

- Change the perception that low-income families can't aspire to a college education for their children.

✓ *Provide parents of young elementary students with information on finding options available for a college education.*

✓ *Continue to hire Hispanic and other minority teachers who provide role models of college graduates for lower income minority students.*

IMPLEMENTED:

✓ The Kern High School District produced 2,500 informational boards of A-F requirements to hang at all schools who wanted them 5th through 12th grades.

✓ The Kern High School District in conjunction with Bakersfield College, California State University of Bakersfield and the University of California has planned College Night at the Civic Auditorium for 6th through 12th grades to explain what is required for attendance to college.

STRATEGY #2:
CHANGE THE CULTURE OF AUTONOMY AMONG THE VARIOUS PUBLIC SCHOOLS AND DISTRICTS IN KERN COUNTY REGARDING EXPECTATIONS FOR COLLEGE PREPARATION.

- Change the perception that elementary districts and schools and high school districts and schools do not have a mutual responsibility to establish a coordinated and sequential set of educational experiences from kindergarten through twelfth grades.
  - ✓ *Establish known benchmarks of expected performance in reading, writing and math at various grade levels for those students preparing for college.*
- Change the perception that a school or district should be concerned with just its own students without reference to how other Kern County schools or districts are educating similar students.

- Change the attitude from one of finding blame for poor college preparation to one of finding how each part of the K-16 system can contribute to greater success in preparing our students for college.
- Change the perception that if a local school's students don't do well in reading, writing, mathematics and study skills, that success in other subjects will prepare them just as well for future school success.

IMPLEMENTED:

✓ Principals from the Kern High School District came together to write an "Action Plan" to increase college enrollment via college preparation classes. (see attached)

STRATEGY #3:

CHANGE THE ATTITUDES HELD REGARDING THE FIRST YEAR OF HIGH SCHOOL, THE NINTH GRADE.

- Change the perception that the ninth grade doesn't really count for college preparatory students since the ninth grade G.P.A. isn't included in college admission criteria.
  - ✓ *Help parents, students and teachers view success in ninth grade academic courses as critical to success in the last three years of high school.*
  - ✓ *Develop a college preparatory path in the ninth grade for each student that includes the specific courses and skills that each individual student will need to be prepared for college level work after high school.*
- Change the perception that a full load of classes is five with one free period or a study hall.
  - ✓ *Assist parents students and staff to understand that six classes is the "normal" high school load for a student.*
- Change the perception that the transition from junior high/middle school to high school is one that all students should be able to make "on their own" without special orientation.
  - ✓ *Provide for orientation to incoming ninth grade students of the study skills and other knowledge they will need to succeed.*
- Change the perception that success in ninth grade college preparatory classes should be limited to only 20-25% of the total ninth graders.
  - ✓ *Enroll more ninth graders in college preparatory course-work.*
  - ✓ *Provide greater follow up and support for ninth graders who are struggling with college preparatory classes.*
  - ✓ *Discuss skills and knowledge that incoming ninth graders need for success with staff of junior high and middle schools.*
- Change the perception that each high school should determine its own individual definition of eligibility for enrollment into college preparatory English, math and other academic subjects.
  - ✓ *Establish more uniform expectations in college preparatory courses among high schools.*
- Change the perception that teaching ninth grade courses are the least demanding teaching assignments in the academic departments, and therefore, assigned to the least experienced or least skilled teachers.
  - ✓ *Assign teachers who are successful in working with ninth graders to the ninth grade college preparatory classes.*
- Change the perception that summer school is for acceleration/enrichment or for remediation of basic proficiency skills.
  - ✓ *Use summer school more extensively for ninth graders who are struggling with college preparatory classes.*
  - ✓ *Use summer school to provide orientation for incoming ninth graders to expectations in college preparatory math, reading and writing within the first year of high school.*
- Change the perception of some parents that once students are in high school, parents no longer have a role in monitoring homework and preparation for classes by their child.
  - ✓ *Ask media, business and social agencies to encourage parent involvement.*
  - ✓ *Encourage the same level of parent support for academics as athletics and other performing groups receive.*

IMPLEMENTED:

✓ Students placed in the wrong courses the first year of high school will not complete the "A-G" requirements ("G" is the new fine arts requirement); therefore, attempts are being made to ensure students are placed in the correct courses beginning freshman year.

✓ The Kern High School District is working to get more students into college preparation classes by emphasizing its importance to parents and students before freshman year.

STRATEGY #4:
CHANGE THE ATTITUDES HELD REGARDING THE LAST YEAR OF HIGH SCHOOL, THE TWELFTH GRADE OR "SENIOR YEAR".

- Change the perception that the twelfth grade focus puts primary emphasis on senior activities, as opposed to academic preparation for the transition to work or college.
  - ✓ *Coincide testing at end of junior year to determine deficiencies that need to be remediated during senior year for college-bound students.*
  - ✓ *Provide for final review of basic academic skills needed for success in college reading, writing and math so that students will fare well in college proficiency tests.*
- Change the perception that the twelfth grade should be the time for a reduced class load rather than full six classes.
  - ✓ *Provide additional teaching staff to allow all students to be enrolled in six classes without increasing overall class size.*

IMPLEMENTED:
- ✓ Graduation requirements have been increased from 200 to 220 units.
- ✓ More challenging courses are being offered for senior year. Students are no longer allowed to take courses, including Government, during the summer, which prevents a shortened senior year.
- ✓ The Kern High School District is emphasizing to parents the importance of all four years of high school.

KERN COUNTY NETWORK FOR CHILDREN
DROPOUT INDICATOR SUB-COMMITTEE
Kelly F. Blanton, Chairperson

NUMBER OF K-12 DROPOUTS

STRATEGY #1:
CREATE A PROCESS BY WHICH WE CAN TRACK AND COLLECT DATA REGARDING DROPOUTS IN KERN COUNTY

- Create a common instrument that feeds into a Common database using a standard student identifier number.
- Identify mechanisms that are already in place at school sites to track this population.
- Foster interagency collaboration by communicating and cross-checking this data with other agencies.
- Encourage schools and their districts to both track and address challenges of specific students who are identified as being on a dropout track.

Recommendation:
✓ Create a common instrument that feeds into a common database using a standard student identifier number.

IMPLEMENTED:
✓ The Kern County Superintendent of Schools through its Financial Crisis Management Team (FCMAT) is currently working to implement within the next five years CSIS (California School Information Services). The CSIS Mission is to:

Build capacity of Local Education Agencies to implement and maintain comparable, effective, and efficient student information systems that will support LEA daily program needs and promote the use of information for educational decision-making by school-site, district office and county staff.

Enable the accurate and timely exchange of student transcripts between Local Education Agencies and to postsecondary institutions.

Assist Local Education Agencies to transmit state reports electronically to the California Department of Education, thereby reducing reporting burden of LEA staff.

Recommendations:
✓ Identify mechanisms that are already in place at school sites to track this population.
✓ Foster interagency collaboration by communicating and cross-checking this data with other agencies.
✓ Encourage schools and their districts to both track and address challenges of specific students who are identified as being on a dropout track.

STRATEGY #2:
SPECIFICALLY TARGET THE SKILL OF READING AS A PRIMARY FOCUS FOR ALL K-12 STUDENTS

- Develop a broad coalition/task force made up of educators, business people, social service agencies, parents and other community members whose responsibility it is to identify, bring attention to and address the challenges of those students from kindergarten through 12th grade who have not learned to read at an appropriate level.
- Work with that coalition, and local district and county office of education reading specialists, to invite input and to develop and implement recommendations and strategies designed to bring all low-reading students up to grade level.
- Develop a public awareness campaign, which heightens the importance of reading as a skill critical to life success.
- Support other community efforts targeting literacy.

Recommendations:

- ✓ Develop a broad coalition / task force made up of educators, business people, social service agencies, parents and other community members whose responsibility is to identify, bring attention to and address the challenges of those students from kindergarten through 12th grade who have not learned to read at an appropriate level.
- ✓ Work with that coalition, and local district and county office of education reading specialists, to invite input and to develop and implement recommendations and strategies designed to bring all low-reading students up to grade level.
- ✓ Develop a public awareness campaign, which heightens the importance of reading as a skill critical to life success.
- ✓ Support other community efforts targeting literacy.

STRATEGY #3:

IDENTIFY COMMONALTIES AMONG DROPOUTS AND ADDRESS CAUSATIVE FACTORS

- Use the results of a local study regarding the causes of the dropout problem in further creating and refining our local strategies to reduce dropouts. The study identifies factors which are common nationally, the specific causes of dropping out of school in our county by region and current programs targeted to dropouts, including those offered by non-school agencies.
- Specifically target dropouts who are pregnant or parenting students with programs that recognize their special scheduling, childcare and other needs.
- Encourage the development of an articulated K-12 curriculum, which teaches better overall decision-making and goal-setting skills in all students.
- Create a public relations campaign that heightens the public's awareness regarding the primary causes that lead to dropping out of school, as well as resources which parents and dropouts/potential dropouts can use to find assistance. Specifically focus on teen pregnancy prevention and on increasing school/parent communication.

Recommendations:

- ✓ Use the results of a local study regarding the causes of the dropout problem in further creating and refining our local strategies to reduce dropouts. The study identifies factors which are common nationally, the specific causes of dropping out of school in our country by region and current programs targeted to dropouts, including those offered by non-school agencies.
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- ✓ Create a public relations campaign that heightens the public's awareness regarding the primary causes that lead to dropping out of school, as well as resources which parents and dropouts / potential dropouts can use to find assistance. Specifically focus on teen pregnancy prevention and on increasing school / parent communication.

STRATEGY #4:

IDENTIFY AND USE SPECIFIC LEVERAGE POINTS THAT ARE IMPORTANT TO DROPOUTS/POTENTIAL DROPOUTS AND THEIR FAMILIES.

- Push for legislation that identifies sufficient school attendance as a primary prerequisite for the issuance and possession of a work permit and communicate with the local business community about such a requirement.
- Push for legislation, which identifies sufficient school attendance as a primary prerequisite for the issuance and possession of a provisional California Driver's License or Learning Permit.
- Take best advantage of the CalWorks regulations, which require families receiving AFDC to demonstrate adequate school attendance on the part of their minor dependents.
- Issue cards to those receiving work permits that identity those who have maintained a certain level of school attendance and enlist the business community's assistance in showing hiring preference to those students.

Recommendations:

- ✓ Push for legislation that identifies sufficient school attendance as a primary prerequisite for the issuance and possession of a work permit and communicate with the local business community about such a requirement.
- ✓ Push for legislation, which identifies sufficient school attendance as a primary prerequisite for the issuance and possession of a provisional California Driver's License for Learning Permit.
- ✓ Take best advantage of the CalWorks regulations, which require families receiving AFDC to demonstrate adequate school attendance on the part of their minor dependents.
- ✓ Issue cards to those receiving work permits that identify those who have maintained a certain level of school attendance and enlist the business community's assistance in showing hiring preference to those students.

STRATEGY #5:

SUPPORT THE RECOMMENDATIONS OF THE TRUANCY INDICATOR AND COLLEGE PREP COMMITTEES AND ENSURE THAT THE RECOMMENDATIONS FROM EACH COMMITTEE COMPLEMENT THE OTHER.

WORK PLAN

RESULT #1: INCREASE CHILD CARE OPTIONS

NEEDS	PARTNERS/RESOURCES	STRATEGIES	SUCCESS MEASURES	
FEW CHILD CARE OPTIONS	Community Connection for Child Care, Parents, Volunteers, Local Agencies, Students, School District, Family Advocate	Evaluate child care status, facilitate licensure readiness, facilitate formation of cooperative child care groups, provide service learning, redirect funding	**1997-1998**	Develop child care cooperative
			1998-1999	Identify 2 licensed providers
			1999-2000	
DECREASED ACCESS TO ADULT EDUCATION	School District, Parents, Agencies	Provide classes in East McFarland	**1997-1998**	5% increase in GED graduates
			1998-1999	
			1999-2000	
DECREASED ACCESS TO EMPLOYMENT	Parents, Volunteers	Install referral systems at Family Center	**1997-1998**	Provide 25 referrals
			1998-1999	2% increase in employment
			1999-2000	2% increase in employment
DECREASES ACCESS TO HEALTH SERVICE	Clinica Sierra Vista, Parents, Volunteers	Mobile unit in neighborhoods, Provide volunteer child care	**1997-1998**	1 visit, 3% inc. CHDP exams
			1998-1999	2 Visits, 6% inc. CHDP exams
			1999-2000	

RESULT #2: INCREASE ACCESS TO ADULT EDUCATION

NEEDS	PARTNERS/RESOURCES	STRATEGIES	SUCCESS MEASURES	
ADULT EDUCATION/ESL	School District, Parents, Volunteers	Provide transportation vouchers, Implement classes, Develop child care coop/transportation	**1997-1998**	Develop 2 evening classes
			1998-1999	5% increase in graduates
			1999-2000	
ADULT ED/ESL DAYTIME	School District, Parents, Churches	Identify off-campus classroom, Provide transportation, Develop child care	**1997-1998**	Identify campus sites
			1998-1999	Develop one class
			1999-2000	5% graduate increase
LIMITED EMPLOYMENT	School District, EDD, Parents	Redirect/identify new funding and job opportunities, Develop child care and transportation co-ops, Provide transportation/child care	**1997-1998**	Establish 1 co-op each for child care & transportation
			1998-1999	3% decrease in unemployment
			1999-2000	3% decrease in unemployment
JOBS FOR TEENS	School District, Volunteers, Chamber of Commerce	Increase efforts to identify placements Expand service learning	**1997-1998**	Redirect services
			1998-1999	5% increase in placements
			1999-2000	

RESULT #3: IMPROVED JOB TRAINING / DECREASE UNEMPLOYMENT

NEEDS	PARTNERS/RESOURCES	STRATEGIES	SUCCESS MEASURES	
JOB OPPORTUNITIES	Chamber of Commerce, City Government, EDD	Continue to explore feasibility of attracting new business, Identify jobs in neighboring cities	**1997-1998**	Increase local job pool by 2%
			1998-1999	3% decrease in unemployment
			1999-2000	
JOB TRAINING/CAREER COUNSELING PROGRAMS	School District, Chamber of Commerce, City Government, EDD	Expand job training, Redirect or identify funding for internships	**1997-1998**	Increase training enrollment
			1998-1999	
			1999-2000	
INTER-CITY PUBLIC TRANSPORTATION	City & County Government, School District, Businesses, Parents, Volunteers	Develop car pools, Develop Co-op transportation, Redirect funds for inter-city transport	**1997-1998**	Form committees to research options/funding
			1998-1999	10% increase in local ridership
			1999-2000	Implement inter-city trans.

RESULT #4: IMPROVE COMMUNITY SAFETY

NEEDS	PARTNERS/RESOURCES	STRATEGIES	SUCCESS MEASURES	
ACCESS TO RECREATION ACTIVITIES	Recreation & Parks, Churches, Parents, Sheriff's Dept., School District, Henrietta Weill, Project Impact, Mental Health	Provide scholarships for youth activities, Sustain adult soccer league, Adopt county-wide truancy policy, Increase access to drug treatment programs, Increase teen employment, Neighborhood watch, Furnish Gymnasium	**1997-1998**	5% increase in adult & youth participation in recreation 5% decrease in gang activity 3% reduction in truancy
			1998-1999	5% increase in jobs for teens
			1999-2000	

RESULT #5: INCREASE ACCESS TO MEDICAL/DENTAL SERVICES

NEEDS	PARTNERS/RESOURCES	STRATEGIES	SUCCESS MEASURES	
IMMUNIZATIONS	Head Start, Public Health Dept., Clinica Sierra Vista (CSV)	School-site Clinics, Community Clinics	**1997-1998**	2% increase in immunization
			1998-1999	
			1999-2000	
CHDP EXAMS	Public Health Dept., CSV	School-site Clinics, Community Clinics	**1997-1998**	5% increase in exams
			1998-1999	
			1999-2000	
DENTAL SERVICES	CSV, CHDP, Healthy Start (HS), Private Dentists	Educate dental community and families, Increase CHDP exams	**1997-1998**	Identify 1 dentist 10% increase in CHDP exams
			1998-1999	Identify 2 dentists 20% increase in CHDP exams
			1999-2000	
TEEN PREGNANCY	Parents, Youth, CSV, AFLP, School District	Preventative education, Counseling, Direct service	**1997-1998**	5% reduction
			1998-1999	

NEEDS	PARTNERS/RESOURCES	STRATEGIES	SUCCESS MEASURES	
			1999-2000	
ALCOHOL & DRUG TREATMENT	Public Health Dept., Project IMPACT	Adult Services, Youth services	**1997-1998**	Serve 10 adults Serve 10 students
			1998-1999	
			1999-2000	
MENTAL HEALTH SERVICE	Henrietta Weill, School District, Student Asst. Teams, Multi-disciplinary Team, Family Advocate	a) Referrals b) "Market" availability of services during summer c) Summer access to services d) Divert to services	**1997-1998**	a) 10% increase b) Develop handouts for parents c) Increase access 10% d) 2% increase
			1998-1999	a) 10% increase b) Develop 2 media promos c) Increase 20% d) Increase 15%
			1999-2000	
ABSENCE RATES	Schools, AFLP, Multi-disciplinary teams, Student Asst. Teams, Parents, Health care providers, Family Advocates	Adopt County Head Lice Protocol, CHDP exams, Referral	**1997-1998**	Reduce absences 5%
			1998-1999	Reduce 10%
			1999-2000	

Anytown City School District
Highest Priority Outcomes by School Site

School	Priority #1	Priority #2	Priority #3	Priority #4	Priority #5
Elementary 1	Getting a job/job training	Increasing children's after school/weekend activities	Reducing child's emotional/behavioral problems; improving parent coping skills or family relationships	Reducing neighborhood violence/gangs	Improving child's school performance; getting more involved in school
Elementary 2	Improving child's school performance	Increasing parenting skills	Getting regular dental care	Getting a job/job training	Reducing child emotional/behavioral problems
Elementary 3	Reducing child emotional or behavioral problems	Helping child with homework; improving child's school performance	Improving parent coping skills or family relationships	Reducing neighborhood violence/gangs	Increasing parenting skills
Elementary 4	Improving parent coping skills or family relationships	Improving parent coping skills or family relationships	Reducing neighborhood violence/gangs	Improving adult's education	Increasing parenting skills
Elementary 5	Reducing child emotional or behavioral problems	Helping child with schoolwork; improving child's school performance	Reducing neighborhood violence/gangs	Getting regular health and dental care	Getting financial assistance/aid
Elementary 6	Reducing neighborhood violence/gangs	Reducing child's emotional/behavioral problems; improving parent coping skills or family relationships	Getting a job/job training	Getting regular health and dental care	Improving child's school performance
Elementary 7	Reducing child's emotional/behavioral problems	Increasing parenting skills	Increasing children's after school/weekend activities	Improving child's school performance	Getting regular health care

OBJECTIVES WORKSHEET

1. What activities will you be engaged in?

A) All activities should logically flow from the objective. It should be clear how the activity reasonably connects to the objective, and how it will lead to the achievement of the objective. For example, if the objective is to decrease violence and the activity is mentoring, the program should explain how the mentoring activity would decrease violence. Who is being targeted - Victims? Victimizers? Gang members? What will mentoring focus on - Prevention? Intervention? Changing behaviors? How will mentees be selected/referred?

B) The narrative should be descriptive. There should be a reasonably clear picture of what the activity entails. The more known about who does what, when and how, the easier it will be to assess the feasibility of the rest of the evaluation plan. If you don't understand the proposed activity, you will not be able to determine if the measures, standards and instruments are appropriate.

A word of caution, we tend to bring our own images to what we read. Sometimes we bring a more descriptive image than what is reality; other times a less descriptive image. In either case, we should strive to have the real image provided. In short, it may be prudent not to fill in too many gaps, or read too much between the lines, without consulting the authors of the proposal. It is important that you be able to determine accurately what activity is being performed. It should be fairly clear exactly what members will be doing, to whom, and for how long. AND who will be supervising members, how often.

C) Each activity should be dearly listed Be aware of "multiple" activities. In most cases, if activities under the same objective are significantly different each will need a separate evaluation plan. Multiple activities listed as one activity only makes the rest of the evaluation plan confusing and ineffective. For example, mentoring and tutoring are, most likely, not the same activity and each should have their own evaluation plan.

Many programs tend to combine activities. For example, an activity of “clean up and tree planting in public parks”, is most likely two activities. Clean up and planting would probably not be measured in the same manner, nor would they necessarily have the same standard. Each of these activities would require its own evaluation plan. Another example is "tutoring". Tutoring can mean at least three different activities and each of these activities usually requires its own evaluation plan:

- Tutoring of the same student or students on a regular basis for a determined amount of time (one to one or small group).

- Drop-in tutoring where the tutee can come one or fifty times (there is no schedule). Student attendance is irregular by design.

- In-class assistance where members are assigned to a classroom and assist both teacher and students as needed. The member "tutors" students as they indicate a need for assistance (raising a hand).

2. What is the hoped for result of the activities described above?

A) The desired result should flow logically from the activity (which flows from the objective). It should also be reasonable and feasible. Usually the desired result will strongly parallel the objective. For example, if the objective is to decrease violence, and the activity is mentoring, the desired result of the activity should be to decrease violence. Basically, the result of the activity should move the program toward the achievement of the objective.

B) Usually each objective will have one desired result. All activities under the same objective should have the same or very similar results. Differences among activities are usually clear in the standard and measure sections of the evaluation plan.

3. How will you measure the quality of these activities?

A) The tools selected should provide the most direct and concrete measure activity impact. The purpose of the tools is to provide a method to collect the information necessary to answer the impact question. For example, the activity is to instruct children on fire safety, the question is; did the children learn the important actions to save their lives? A satisfaction survey of the teachers may tell you that the presentation was interesting and stimulating and that the children paid attention but it would not be the most direct or the most concrete manner in which to answer the impact question. You would not know if the children learned.

B) The measure begins to test the feasibility of the desired result. This is one place where you can test the feasibility of the desired result. For example, the activity is to give presentations on pregnancy prevention, and the desired result is to decrease teen pregnancy. The impact question is; did teen pregnancy decrease? It would probably not be appropriate to use pre/post teen pregnancy rates as a measure of success. It is unlikely that the presentations would have either an immediate or widespread impact. Most likely this measure would not assess the actual impacts of this activity. Actually, a better result may be to educate teens on pregnancy prevention. Success can be measured by pre/post-tests on the presentation information. Further a follow-up survey or (better) focus groups could be used to measure retention of information or work on peer pressure issues. These measures would assess impacts of the activity.

C) The program can use multiple measures for the same activity. For example, in a tutoring activity the actual work of the tutee can be measured with tutoring logs, a teacher report can capture the performance of the tutee in the classroom, and a tutee survey can measure the impact the tutee feels. Ideally, multiple measures (which can be simple give the program more robust feedback on the work of the program, and serve to improve the program.

D) The program should identify exactly what tools it intends to use to collect which information. It is extremely helpful for you to know how often the measure/tool will be used to collect data. For example:

- pre -post test for each presentation to measure knowledge
- quarterly survey to measure satisfaction
- monthly observation to measure demonstration of skills
- quarterly focus groups to measure demonstration of skills (debriefing, problem solving, conflict resolution, anger management, etc.)
- sign-in sheet to record numbers in attendance for every activity
- weekly activity log to record what was done, for how long, and by whom
- interview guide to collect satisfaction and needs information, semi-annual
- checklist to assess procedural/process information, collected monthly

4. By what standard will you gauge success?

A) How much change is expected? This section should tell you exactly what level of the desired result will be achieved. The program should use numbers in this section. For instance, *75% of high risk youth tutored.....*

B) What exactly is expected to change. Aside from the number of people or things that will change, you should also know what will change (or be accomplished), and how much. For example, *75% of high-risk youth tutored will successfully complete 85% of their tutoring goals.*

C) Every measure needs a standard. Each measure/tool cited in question 3, needs to have a specified standard.

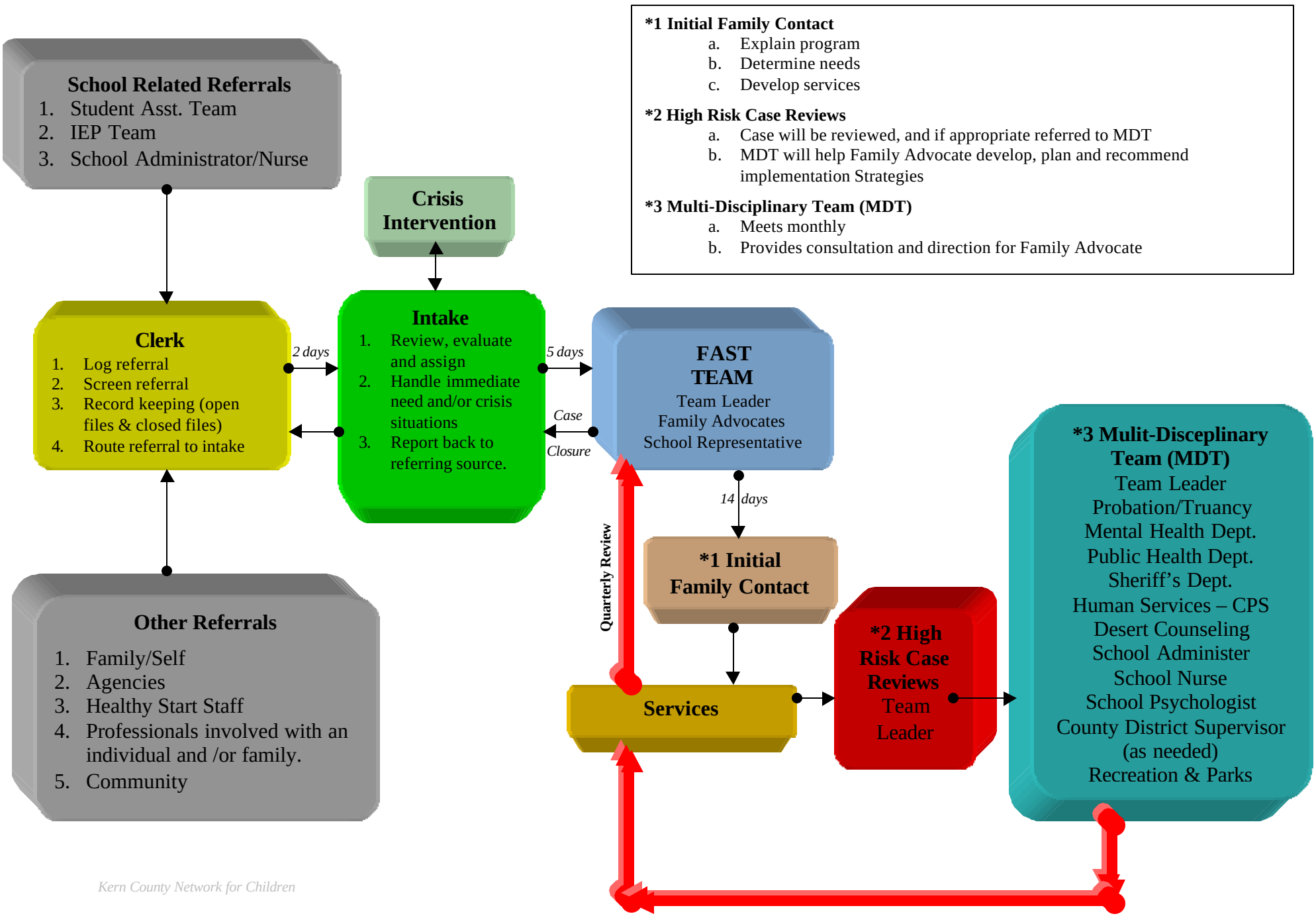
SCOPE OF WORK
January 1, 2000 – December 31, 2001
Anytown Collaborative / Fiscal Agent: Anytown Counseling Center

Emphasis: Expansion and the integration of case management services including immunizations, mental health services, and outreach to area pre-schools to prepare children to learn.

Results Statement	Objective	Activities	Short Term & Performance Indicators	Long-Term Outcome Indicator	Data Collection Methodology
Increase the number of children raised in families that are able to support their optimal development.	An increasing number of families with children that are accessing preventive services.	1. By providing early intervention (Ages 0-5) through integrated case management addressing "at risk" factors will support healthier and safer children ages 0- 5. Interventions provided to at least 50 children and their families will include, but are not limited to the following. Grant funds will be used to fund 50% of a Family Advocate in order increase to services: a. Referrals will be screened and referring party contacted and linkages to services for the health and well being of the children and their families will begin. b. Family contact is made and needs are assessed. Needs will be identified and a case plan developed to meet the needs. Services will be implemented until goals are met or the client refuses services. If family	1.a 90% of the children 0-5 years of age that are referred to the Intervention Team will be fully immunized, receive CHDP and be link to prenatal if needed. 1.b There will be a 10% reduction in absenteeism of pre-school children at Anytown Elementary School from students that are referred to the Intervention Team. 1.c 75% of the families referred for mental health services will receive counseling. 1.d 50% of the parents or guardians of children with special needs will successfully meet their goals outlined in their family service plan.	▪ Increase in the percentage of children who receive services, immunized for DTP, MMR, and polio by age 2. ▪ Increase in the percentage, children who receive services, served by Child Health and Disability Program (CHDP) screenings. ▪ Increase in the percentage of women, who receive services, accessing prenatal care during the first trimester.	Data collection is a vital element of the integrated case management model and the following methodologies will be utilized. a. Referrals will be logged and the intake person will assess and assign to the Intervention Specialist or Family Advocate. b. If client refuses services, information as to why they refused services will be charted. c. If client accepts services their needs and the developed case plan will be logged. d. All contact and outcomes will be logged and tracked for each client, including the information regarding the number of receiving CHDP, immunizations, and prenatal care. e. Cases will be reviewed at least every three months. When client meets their intended goals, the case will be closed and kept on file. f. The number of children

		refuses services, the Intervention Team will evaluate other methods of outreach to the family.			and families participating in services will be logged and tracked. Services may include social skills groups, individual therapy, etc. g. Referrals for food and clothing will be logged and tracked. All information pertaining to the indicators will be reported. This will include the total number of families and children served 0-5 with special needs.
		2. Aggressively pursue private and government funds that can be utilized to sustain services at the conclusion of the grant period.	2.a Meet regularly to identify potential resources. 2.b Submit grant applications as they are made available.		2. Potential financial resources will be identified and steps (e.g. grant application, time studies, etc.) will have been taken to request access to them.
		3. Utilize an evaluation system that focuses on "Results Based Accountability.	3.a Participate in "Results Based Accountability" trainings. 3.b Develop and/or expand utilize existing data collection tools/methods.		3. Quantitative tools and qualitative methodologies will be available for review.

REFERRAL/SERVICES FLOW CHART



Introduction

The staff of the Any-Town Community Collaborative has been providing case management services in Any-Town for over two years. Through their efforts many families have received services which have resulted in improved family functioning through these experiences a philosophy and Service Delivery System has evolved and has been effective in many situations.

Their philosophy has several components:

- The first component is a belief that most individuals want to be successful in life and feel good about themselves, most parents want to raise their children appropriately and feel a sense of pride in this role. Accepting this concept is important because services can be organized and directed towards helping people overcome the obstacles blocking these feelings of personal fulfillment.

- The Service Delivery System which is linked to this idea is based on a concept of using a non traditional approach in working with adults, children and families. The system is client centered and is flexible in providing for crisis intervention, short and/or long term interventions. The goal is to provide the necessary support and resources while working to empower families to become self sufficient in providing for their needs.

It is recognized that parents, families and surrogate families are a child's strongest advocate. Parents have social and legal responsibility for themselves and their children as well as an emotional investment in their children. Parent and professional collaboration is necessary (if not mandatory) to best meet individual, parent and child needs. It is critical that the staff of Any-Town Community Collaborative view individuals and parents as resources and full participants in all aspects of planning, assessment and service delivery. The relationship of service staff with the individual, child, and family should involve an understanding and appreciation for their culture. Services are provided with extreme confidentiality and without the staff imposing their own beliefs and morals.

Services provided by Any-Town Community Collaborative staff will be directed toward a goal of providing a friendly, non threatening environment where families, individuals and children are accepted, given hope, and provided with services to break down barriers which will hopefully lead to an improved quality of life. This in turn will eventually lead to stronger, safer, and improved community environments. Services provided will be family focused, but child centered (staff must be aware of the safety of children). Services provided will focus on the total family and the internal and external variables that impact family members. Parents, children, and individuals will be treated with respect and all staff will convey the feeling they are valued persons.

Staff of the Any-Town Community Collaborative will be caring, be non judgmental and respond as quickly as possible to family needs in order to provide hope for a better future. Staff will

establish and maintain a trusting relationship with the people they serve. The emphasis will be directed to empower the family to resolve their struggles and advocate for their needs instead of doing things for them. The idea is to strengthen individuals, by building self esteem, self-confidence, pride, independence vs. feeling sorry for the individuals providing services which lead to dependency. Staff must also be continually aware that Any-Town is a culturally diverse community and services should be delivered in a sensitive manner and language barriers must be bridged.

In summary the following case management structure has been developed which is designed to meet the needs of the Any-Town Community. Services will be community based, client driven and agency staff must understand this concept when providing services through Any-Town Community Collaborative. It is further recognized that structure in a Service Delivery model is important, but should be flexible enough to accommodate the needs of the community. Individual, parent, child and family needs will be recognized as the most important issue by all staff.

Referral Source:

A. A Parent, other family members, relatives, a collaborative agency, school personnel, and other professionals who may be involved with a family and/or child may initiate a referral for Any-Town Community Collaborative. (e.g., Physician, Dentist, Therapist, Law Enforcement, Social Worker, Case Manager, Nurse etc.).

B. Throughout the process from referral until closure the tools for assessment, evaluation and data collection and any other required case management forms must be utilized upon a referral. A case file will be developed for each family and will contain logs, consent forms, identify other agency involvement, service plans, intervention attempted and outcomes. When the involvement of Any-Town Community Collaborative is discontinued the case will be closed and forwarded to closed files which will be maintained at Any-Town Community Center for a period of not less than three years. **Information in the case record will not be released to any other person/agency without parent authorization.**

Referral Procedures:

All referrals will be forwarded to the clerk where the following actions will occur.

1. The referral will be screened to check that all necessary information has been completed.
    a. If additional information is required the clerk will contact the reporting party and request this information.
2. From the referral forms the clerk will log the following information:
    a. The date the completed referral was received.
    b. The referral source.
    c. Child's/Client's name.
    d. Parent/Family name.
    e. Reason for the referral.
    f. Date the referral was routed to Intake.
    g. Program funding type - (e.g., Prop 10, TCE, Healthy Start, FPSP, etc.)
3. The clerk will attach the referral to a case folder when routing to Intake. The exception to

this process will occur if a serious crisis and/or immediate needs are indicated. If either of these problems are identified the clerk will immediately alert Intake where the situation will be reviewed and if necessary the appropriate services will be initiated to resolve the initial emergency as quickly as possible.

4. Following this action the referral process will revert back to the planned process.

Intake Procedures:

The following actions will occur during this process.

1. The referral will be reviewed and evaluated to determine if it is appropriate for services.
2. If appropriate, the Intake person will contact the referral source and gather further information about the individual/family's presenting problem.
3. Will complete and return the information form to the referral source. The information on this form will include the date the referral was received and when it was assigned to an Family Service Advocate. The name and phone number of the FSA will also appear on this form.
4. This process will be completed, if no immediate action is necessary within five working days.
5. The Intake person will log the following information:
   *Date case assigned to FSA
   *Name of FSA (this information will be given to the clerk)
   *Dates for 30 day plan.
   *Case review dates.
   *Closing date.
   *If goals of case management were met.
   *Will establish due dates for family assessment, family profile and case plan.

ASSIGNMENT "TO" AND "ROLE" OF THE FAMILY SERVICE ASSISTANT TEAM

Philosophy:

1. This group must share a common goal; “The Family's” must be committed to team decisions, be client centered, communicate openly and honestly and collaborate, not compete.
2. The FAST Team must function as a positive, open, cooperative and confidential group.
3. All members are equally important and all other team members will respect their feelings, information and opinions.

Team Member Roles:

1. Team Leader (FSA Supervisor): Will provide leadership and structure.
   a. Specific tasks include: assigning cases, insuring that all required data forms, case plans, etc. are completed within expected time lines, providing consultation and support to team members accompany FSA's, Outreach Workers, Intervention Specialists on client contacts when necessary and provide direct services. The Team Leader will review team cases quarterly, will organize and lead team meetings and provide individual time for each team member. In addition the Team Leader will communicate with staff from agencies providing services to Collaborative individuals and/or families.

2. School Staff Member: will provide information regarding school issues and services

available through the educational system. In addition could provide information on child development and/or in other areas of his/her expertise.

3. Family Service Assistants, Outreach Workers, and Intervention Specialists: these team members will provide direct services to individuals and/or families and will serve as the families' primary contact. It should be noted that the above staff **<u>are not</u> therapists, doctors, etc, but are persons who assist the individual and/or family in overcoming the obstacles which prevent individuals and/or families from securing and utilizing necessary services to resolve problems. Their primary roles are to: 1) provide linkages to services 2) empower clients to advocate full access to the services they need.**

Specific tasks will include:

- ❖ Establishing and maintaining a trusting relationship with individuals and/or families including strictly adhering to confidentiality policies and procedures.
- ❖ Ensuring that basic family needs are met (food, clothing, shelter)
- ❖ Assisting the individual and/or family in identifying physical, emotional, medical, educational needs etc. and securing resources for the family to address these issues
- ❖ Providing support and acting as an advocate when necessary.
- ❖ Communicating with other agency personnel involved with the individual/family to ensure services are appropriate and effective, which will also lead to a reduction of duplication of services.
- ❖ Maintaining a case record on all families in their caseload.
- ❖ Completing all required forms, case plans, family profiles etc. according to time lines and maintaining contact logs.

Upon receiving a referral the FSA's, Outreach Workers and Intervention Staff will make an initial family contact within 14 calendar days from that date. The goals of this first meeting will include:

1. Explaining the reasons for the referral, listening to parent's feelings, identifying parent concerns and their perceptions of the problems, answering questions about possible services and assisting the parent in the decision whether pursue services. Sharing information about the range of services available to assist individuals and/or families in the problem solving process. The FSA will make every attempt to be culturally and/or linguistically sensitive when necessary in order to establish rapport within the individual and/or family. The individual and/or family member and will be made aware that information gathered during interviews is confidential will only be released with their authorization. The exception to this procedure can occur if the staff member believes a child is in danger or is possibly a victim of abuse and/or neglect. **In this scenario, a report of suspected abuse must be filed immediately to the Department of Human Services.**

2. If an individual and/or family is receptive to and accepts services the needs will be identified and prioritized with the individual and/or family member. A family profile and family service plan will be developed and later reviewed by the Team Leader. The Team Leader will discuss the case and assist the FSA in resource development.

3. If an individual and/or family member rejects services the situation will be discussed with the Team Leader and options will be explored on how to proceed. When appropriate, a second contact will be made within two weeks following the initial visit with individual and/or family members to further explore their concerns and if services are again rejected assurance for reconsideration of services at a later date will be communicated to the client.

4. The referral process will be completed within 30 calendar days of the referral date. Services provided will be child centered/family focused and will continue until one of the following occurs:
    a. All goals are met.
    b. Parents request services be discontinued.

Discontinuing Services Procedures:

When closing cases the FSA will discuss the termination of cases with the Team Leader. The Team Leader will review the case with the team member to insure all levels services have been provided, and the appropriate closing forms are competed. (e.g., Post Family Assessment & Termination Form, etc.). If there is a child attending school, notification will be provided to the member of data collection so a post teacher assessment can be completed. The Team Leader will complete the appropriate form and route to the reporting party regarding this action.

THE ROLES OF THE MULTI DISCIPLINARY TEAM (MDT)

A. Composition: The MDT, which is chaired by the Collaborative Coordinator, will consist of a of agency personnel representing social service agencies, law enforcement, schools, etc., who provide services in Any-Town. Representatives from collaborative agencies will make up the core group. Other agencies could be asked to participate as needed.
B. Role and Function: The MDT will meet monthly. The primary function of this group will be to listen to presentations about cases that are unique and complex and assist the FSA with developing appropriate case plans. A second function of this group is seen as providing training and information for FSA's to improve their skill levels and networking about services in Any-Town, obstacles to success and develop strategies to overcome the obstacles to ensure services will become as successful as possible.
C. Procedure: Case situations that will be discussed by the MDT team will proceed in the following manner: Following a meeting between the FSA, Outreach Worker, and the Team Leader, a decision will be made whether or not to refer to the MDT team. If in the opinion of these individuals the case needs to be brought to the MDT, the Collaborative Coordinator will review it before placing on the agenda. If appropriate the Team Leader, FSA, Reporting Party, and if possible the client should attend this review.
D. Outcomes: This group will provide consultation, support and direction for case management services to overcome obstacles blocking successful implementation of a service plan. Specific tasks of this team will range from providing information and resources to the FSA to assisting, if necessary, the FSA with intervention.

SAMPLE LETTER OF INVITATION

Anytown Community Collaborative 234 Main Street Anytown, CA 93562 312-888-9900

September 19, 2001

Dear Service Provider / Principal:

The Anytown Community Collaborative has begun the process of developing an integrated case management system to serve the community in Anytown. Our goal is to bring together current school and agency resources and develop a comprehensive system that would be operational by September 2001.

Currently case management services have been available through projects such as Healthy Start, County Mental Health Substance Abuse Prevention funds, FPSP, and other service providers who traditionally deliver to the population of Anytown. We believe that by utilizing the philosophy created by the Neighborhood Partnership Projects of redirection and integration of all the current and existing resources we can better serve the community, reduce duplication of services, and provide each of us with a wealth of new resources through collaboration.

We invite you to be a part of a working meeting to put the structure of an integrated case management system together consisting of agencies, schools and other organizations. Participating organizations must be willing to redirect their own existing resources as a part of this integration. In return you will be better able to serve the children and families you work with in a collaborative effort with greater accessibility of resources, as well as many new resources. The meeting will be held at the Anytown Community Center located at 234 Main Street on August 7, 2001 at 10:00 a.m.

The goals of the meeting will be to identify existing resources, integrating and out-stationing resources, staffing and coordination of a case management team, develop a referral and data collection process, a case work flow plan for cases, and a start up date. We will then identify the existing gaps in our service delivery system and look at available FPSP funds to fill those gaps.

Your talents are needed. As we know, fewer and fewer dollars are available to provide services to children and families. It is up to us to find creative ways of supporting their needs and work towards not only healthy individuals, but empowered communities as well. If you should have any questions, or are unable to attend please call John Smith at 888-9900.

Sincerely,

John Smith
Facilitating Coordinator
Anytown Community Collaborative

KERN COUNTY INTERAGENCY

CONSENT AND AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

(Please type / print all information)

Child's Name:_____ Birthdate:_____
(First, Middle, Last)

Social Security #:_____ Client/Record #:_____ Agency:_____

Mother's Maiden Name:_____ Father's Name:_____

Agency/Person/Organization	Agency/Person/Organization
I authorize: _____	_____
_____	_____
_____	_____

providing services for the child/student identified above, to exchange or obtain record/information obtained during the course of my child's treatment, case and/or service plan with the understanding that if, and only if, such exchange of information is deemed necessary to plan or provide needed services.

Restriction of Records or Information: ☐ None ☐ Yes _____
(List Restriction)

I understand that this Consent for Release and Exchange of Records and Information is effective until such time as consent is withdrawn by the undersigned.

I have read this consent carefully.

Please print:_____ Please print: _____
(Parent, Guardian Conservator) *(Parent, Guardian Conservator)*

Signed:_____ Signed:_____
(Parent, Guardian Conservator) *(Parent, Guardian Conservator)*

Please print:_____
(Witness – Agency Representative)

Date: _____ Signed:_____
(Witness – Agency Representative)

CONSENT WITHDRAWN:

Please print:_____ Please print: _____
(Parent. Guardian, Conservator) *(Parent. Guardian, Conservator)*

Signed: _____ Signed: _____
(Parent. Guardian, Conservator) *(Parent. Guardian, Conservator)*

Please print:_____
(Witness – Agency Representative)

Date:_____ Signed:_____
(Witness – Agency Representative)

Original Copy - Agency
Carbon Copy- Client

RELEASED RECORDS

(Must be completed prior to release)

The following hard copy records were released to:_____

___Summary of Record

___Diagnosis/Assessment

___Social History

___Treatment Plan

___Psychiatric Evaluation

___Medical Assessment, Lab Tests, etc.

___History of Drug/Alcohol Abuse

___Evaluations/Assessments (specify)

_____

_____

___Results of Psychological/ Educational/Vocational Testing

___Other (specify)

_____

_____

_____

_____

_____

_____

_____

_____

Reason for Release:

_____

_____

_____

_____

_____

Released by:

SIGNATURE:_____

TITLE:_____AGENCY:_____

DATE:_____/_____/_____

Month *Day* *Year*

CHILD'S NAME_____ BIRTHDATE:_____

SOCIAL SECURITY # _____ CASE/CLIENT #:_____

AGENCY:_____

SERVICIOS DE INTERVENCIÓN TEMPRANA DE KERN

CONSENTIMENTO DE LOS PADRES O TUTORES PAR4 OTORGAR E INTERCAMBIAR ARCHIVOS E INFORMACIÓN

Nombre del niño:_____ Fecha de nacimiento:_____
(Según el acta de namimiento)

Seguro Social #:_____ Cliente/Archivo #:_____ Organización:

Apellido de nacida de la madre:_____ Nombre del padre:

Yo autorizo a las siguientes organizacienes/personas/grupos que proporcionan services para el nino identificado arriba:

Organización/persona/grupo	Dirección

a intercambiar compartir archivos/infomiación obtenidos durante el curso del tratamiento, del caso y/o de1 plan de servicio de mi niño, entendiendo que tal intercambio sea considerado únicamente para beneficio de mi niño por la organización o el representante que proporciona los servicios.

Restricción de archivos información: ☐ Ninguna ☐ Sí _____
(Indique la restricctión)

Tengo entendido que este Consentimiento y Autorización para Otorgar e Intercambiar Archivos e Información estará en efecto hasta cual tiempo este consentimiento sera retirado por la persona quien autorizo.

He leído y comprendo los términos y la naturaleza de este Consentimiento.
(Firma de los padre/tutores/conservadores)

Nombre:_____ Nombre:_____
(en letra de molde) *(en letra de molde)*

Firma:_____ Firma:_____
(parentesco) *(parentesco)*

Nombre de Testigo:_____
(en letra de molde)

Fecha:_____ Firma._____

RETIRO DEL CONSENTIMIENTO:
(Firma de los padres/tutores/conservadores)

Nombre:_____ Nombre:_____
(en letra de molde) *(en letra de molde)*

Firma:_____ Firma:_____
(parentesco) *(parentesco)*

Nombre de Testigo:_____
(en letra de molde)

Fecha:_____ Firma._____

Original Copy – Agency
Carbon Copy - Client

ARCHIVOS OTORGADOS

(Debe completarse antes do otorgar los archivos)

Los archivos siguientes, en su copia final, fueron otorgados a:_____

____Resumen de1 Archivo

____ Diagnosis/Asesoramiento

____Antecedentes sociales

____Plan del Tratamiento

____ Evaluación siquiátrica

____ Asesoramiento medico (pruebas de laboratorío, etc.)

____ Antecedentes de abuso del alcohol o las drogas

___ Otras evaluaciones/ asesoramientos (especifique)

_____

_____

____Resultados de pruebas sicológicas/educacionales/vocacionales

___ OTRO (especifique)

_____

_____

_____

_____

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_____

_____

_____

_____

RAZÓN POR LA CUAL SE OTORGÓ LA INFORMACIÓN:

_____

_____

_____

Otorgada Por:

FIRMA:_____

TITULO:_____ORGANIZACIÓN:_____

FECHA:_____/_____/_____

Mes *Dia* *Año*

Nombre del niño:_____ Fecha de nacimiento:_____

Seguro social #:_____ Cliente/archivo #:_____

Organización:_____

SUGGESTED CONFIDENTIALITY ORIENTATION

1. Develop a philosophic statement explaining the purpose and proper handling to assure confidentiality:
   - The core interest in privacy ("the right to be left alone")
   - Avoiding embarrassment and humiliation from disclosure of personal or family problems
   - Avoiding exposure of information that is inherently inflammatory (such as allegations of child abuse or mental instability), even if the information is unproven or inaccurate
   - Protecting personal security (such as the location of victims of domestic violence)
   - Protecting family security (such as citizenship status, for immigrant families)
   - Protecting job security, particularly when personal problems may have no connection with actual job performance
   - Avoiding prejudice or stereotyped responses as a result of information on family income level, medical status, or past difficulties
   - Preventing denial of discretionary services
   - Encouraging adolescents to seek medical care
   - Reestablishing privacy boundaries for children, especially after abuse or multiple out-of-home placements.

Balanced with these interests in privacy are the interests of agencies in sharing information. In many situations, children and family share these interests in the effective and efficient provision of services. The interests of agencies (and families) include:

- Conducting comprehensive child and family assessments and evaluations for services
- Providing children and families with all necessary services
- Coordinating service plans and strategies and avoiding duplication of services
- Monitoring the provision of services
- Making services family-focused
- Allowing research on community needs and program effectiveness
- Promoting public safety (e.g., by sharing information about potential child care workers regarding prior criminal convictions)
- Securing full reimbursement from federal and other funding sources for services provided

2. Explain in detail who can and who cannot receive confidential information as it relates to reasonable "right to know" and what is in the minor's best interest

3. Determine an appropriate routing system for the confidentiality form as various agencies become involved in the casework plan.
   - Who initiates the form? - Originating agency.
   - Who signs the form?
     (a) minor
     (b) natural parent
     (c) legal guardian
     (d) conservator
   - How many copies of the form are needed; if any.

(a) a copy to the client/natural parent or legal guardian
(b) original remains with the agency

- Does a copy of the form travel from agency to agency? - Only on request.
- Should there be any ending date included on the form? - Yes & no. Depends on agency policy.
- Shall there be a purging date established when cases are closed? - Yes & no. Depends on agency policy.

4. Site sections of the law pertaining to confidentiality.
   - Section 18986.45 of the Welfare and Institutions/Health and Safety Codes -Disclosure of information and records; members of children's multidisciplinary service teams - (all agencies).
   - Section 827 of the Welfare and Institutions Code - (Probation and Department of Human Services)
   - Sections 1795, 3198 and 3227 of the Health and Safety Code - (Public Health Department).
   - Section 5328 of the welfare and Institutions Code - (Mental Health Department).
   - Section 5328 of the Welfare and Institutions Code - (Kern Medical Center).
   - Sections 49060-49079 of the California Education Code - (Kern County Superintendent of Schools).

5. Explain all the ramifications of Informed Consent.
   - The client possesses sufficient knowledge about the benefits and risks of all treatment alternatives and is intellectually capable of making a reasoned choice among them.

6. Ordering forms / reordering forms.
   - Source
   - Type-NCR
   - Quantity

7. Discuss sanctions against those who break client confidentiality.
   - Section 5330 of Welfare and Institutions Code -Civil remedies for unlawful disclosure of confidential information.
     - Five hundred dollars ($500.00).
     - Three times the amount of actual damages, if any, substantiated by the plaintiff.
   - Criminal sanctions.
     - Guilty of misdemeanor.

JOB OPPORTUNITY
Anytown Community Clinic

FAMILY ADVOCATE
(OPEN)

Anytown Community Clinic in conjunction with the Anytown Community Collaborative announces a screening for the position of Family Advocate. There will be one full time position. Qualified candidates are invited to submit a personal resume along with an Anytown Community Clinic job application form including the supplemental questionnaire to:

Anytown Community Clinic
Attn: Anytown Community Collaborative / John Smith
234 Main Street
Anytown, CA 93652

ALL papers must be received no later than Friday, January 15, 2001.

RESPONSIBILITIES AND DUTIES:
Under the supervision of Anytown Community Clinic's Project Coordinator and ongoing consultation with the Anytown Community Collaborative Social Worker, establish rapport with referred parent/family to share information about the Community Collaborative and services which may assist the family; implement Community Collaborative integrated service delivery system with referred children and families; deal professionally with issues related to confidentiality, student/family records, and interagency agreements; work with the Family Assistance Service team to provide "case management" and ongoing support to referred families; keep required records accurately and make required reports; assist in the development of community services accessible to families in the Anytown Community Collaborative targeted area; serve as a resource to community agency and school staff regarding programs and services offered in the community; perform other related duties as assigned.

MINIMUM QUALIFICATIONS:
Knowledge of how to access community resources including government and other community agencies. Ability to demonstrate non-judgmental cultural and linguistic sensitivity; understand and implement oral and written directions given in English; work effectively and efficiently with minimum supervision; establish harmonious working relationships with parents, clinic staff, school and community agency personnel. Successful experience working in an agency or a school as a volunteer or paid agency paraprofessional capacity. High school diploma or equivalent; valid California drivers license and proof of insurance. Spanish speaking preferred.

SALARY AND FRINGE BENEFITS:
$7.50 - $8.20 per hour, $ 1,200.00 to $ 1,312.00 per month 8 hours per day, 40 hours Per week. Holiday, sick leave and vacation benefits. Medical, dental and vision benefits. Life insurance and pension plan available.

SELECTION PROCEDURES:
Each candidate's complete application will be thoroughly evaluated and ranked by a screening panel. Candidates to be considered that meet the qualifications will be scheduled for an interview with a team of professional experts appointed by Anytown Community Clinic. Interviews will be held the week of January 20, 2001. The successful candidate will report for duty on February 1, 2001.

The provisions of this bulletin do not constitute a contract, expressed or implied, and any of the provisions contained herein may he modified or revoked without notice.

An equal opportunity / affirmative action employer

ANYTOWN COMMUNITY CLINIC & ANYTOWN COMMUNITY COLLABORATIVE

A collaborative effort to serve the people of Anytown.

SUPPLEMENTAL APPLICATION

Position: **Family Service Advocate**
Date Due: **January 15, 2001**

Please provide a brief response to the questions below. Use additional sheets if necessary.

1. Describe how your background and training meets and/or exceeds the minimum requirements of experience and education required to qualify for this position.

2. Briefly describe your reasons for wanting to be a Family Service Advocate working in Anytown.

3. Define "case management." Your definition should include a discussion of the potential benefits to both the client and community.

4. Write a short description of your most significant work or community service experience. In the course of your description be sure to address the following questions:
   a. Why was the experience meaningful to you?
   b. How did the experience help you to grow as a person?

I certify that all statements provided herein are true and correct to the best of my knowledge, and that all statements were prepared by me.

_____ _____

Signature *Date*

An equal opportunity / affirmative action employer

ANYTOWN CITY SCHOOL DISTRICT

Interagency Memorandum of Understanding on Collaborative Planning and Services

This Memorandum of Understanding is for the purpose of outlining general understandings between the Anytown City School District ("District") and
_____("Agency")

The agreed upon understandings are related to the submission of a [NAME OF GRANT] grant application. The two parties are intent on implementing a cooperative effort to serve students and families in the attendance areas of the schools participating in the application. This Memorandum reflects the belief by both parties that improved coordination, communications and integration of services are absolutely essential if appropriate and timely services are to be provided to the designated populations.

UNDERSTOOD RESPONSIBILITIES OF THE DISTRICT:

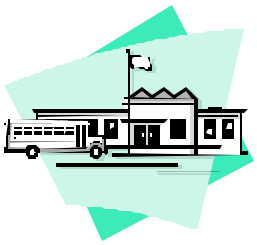
- The District is committed to a [NAME OF PROGRAM] planning process designed to establish integrated service delivery in District schools, commencing with grant approval sometime after [DATE]. The District will assume full responsibility for grant preparation and follow-up, in consultation with members of the community and local service providers.
- The District will assume responsibility for convening collaborative groups to adopt overall policy and guidelines, and for formalizing agreements between various collaborating bodies and agencies.
- The District will convene all collaborative groups during the planning process.
- The District will provide the agency with all necessary and appropriate training required to fulfill the goals and objectives of the grant.
- The District will provide necessary and appropriate training to all school staff and parents of the participating schools.
- The District will serve as the fiscal agent for all grant funds, and will contract for services authorized from those funds.

UNDERSTOOD RESPONSIBILITIES OF THE AGENCY:

- The Agency will participate in the District-wide and school site planning groups as appropriate and necessary
- The agency will provide training to selected District and community participants as appropriate and necessary to accomplish the goals and objectives of the grant.
- The Agency will provide additional assistance as mutually agreed upon by the District and the Agency during the planning process.

_____ _____
Anytown City School District *Date*

_____ _____
Agency *Date*



Anytown City School District

"Experience Learning"

January 1, 2001

Mr. John Smith
Anytown Community Collaborative
234 Main Street
Anytown, CA 93652

Dear Mr. Smith,

The Anytown City School district wishes to continue working with the Anytown Community Collaborative. We are pleased to be an active part of the Coordinating Council, which provides direction for the Collaborative. The Anytown City Schools has four schools that draw directly from the proposed target population.

Our district is committed to improving the educational outcomes of our children. We will use the Anytown Community Collaborative family services team as a resource for our families and children needing assistance. We believe it is important to collaboratively work with other agencies. Our schools will be willing to provide space for referrals to the family service team for their children who need intervention or counseling.

We would be happy to distribute information through our schools to the targeted children and families. In addition, we would consider exploring additional ways to be supportive of the Anytown Community Collaborative.

Sincerely,

Jim Bond

Jim Bond
Superintendent

:jim

Anytown Healthcare Services

January 12, 2001

Dear Selection Committee Members,

This letter is in support of the Anytown Community Collaborative Clinic Project. We are willing to redirect five hours per week of the Project Coordinator's time. We are also willing to provide the following services:

* food baskets to target families
* clothing services to target families
* English as Second Language classes
* Tutoring for children ages 7-10 years of age
* office space for the Family Services Assistant

We currently are providing office space and resources to Project H.O.P.E. Anytown Healthcare Services and Project H.O.P.E are working together to provide tutoring services for children ages 7-10 years of age, who are consider to be at-risk youth.

We are in full support of this proposal. We urge you to support this proposal sponsored by Anytown Community Collaborative. Thank you for your cooperation.

Sincerely,

Jean Gordon

Jean Gordon
Project Coordinator
Anytown Healthcare Services

Mailing Address:
P.O. Box 172
Anytown, CA 93652

Street Address:
12 Cypress Road
Anytown, CA 93652

Phone: (312) 888-1700

Johnson's
"We're all ears"

TO: John Smith
Anytown Community Collaborative

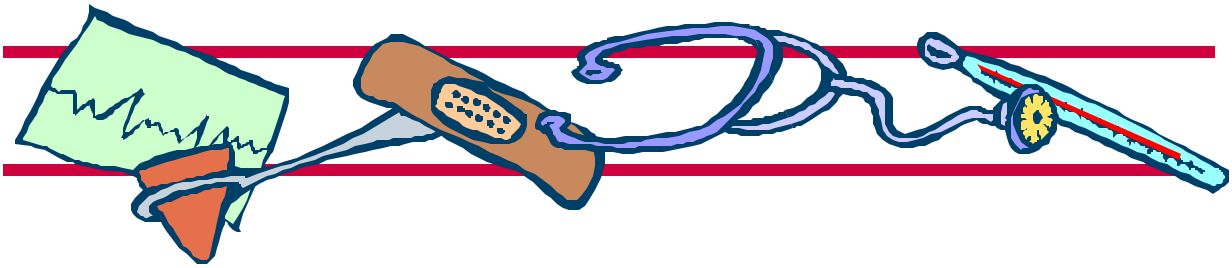
FROM: Jennifer Jans
Assistant Vice President
Administration & Personnel

DATE: January 7, 2001

One of the biggest challenges facing business during the current economic times is keeping our neighborhoods free from crime. As a major employer in the Anytown community, we are concerned for our business, our employee's safety and the well being of the entire neighborhood. As part of our concern, we have selected to work with our neighbors in a coordinated effort to improve, correct and restore pride back into this area of the community.

We are committed to the Anytown Community Collaborative as a partner in improvements and a mentor to future growth and employment.

sw/JJ



ANYTOWN COMMUNITY CLINIC

P.O. Box 457 • 3787 Hail Road • Anytown, CA 93652 • (312) 888-5555

January 22, 2001

John Smith
Facilitating Coordinator
234 Main Street
Anytown, CA 93652

Dear Mr. Smith

Anytown Community Clinic is a private non-profit organization operating nine six community health centers in Any County, which serve low-income and underserved populations. We are committed to being active participants in the Anytown Community Collaborative.

Anytown Community Clinic is presently building a 14,000-sq. ft. health center (Anytown Community Health Center) in the target area for Anytown Community Collaborative. We are committed to increasing the primary care available to area residents, including specific targeting of well child exams and immunizations for area children.

Mr. Tom Carson will participate as the coordinator/liaison from the Anytown Community Health Center. Staff from the Anytown Community Health Center will be available to participate "on site at Anytown Elementary School in the case management of families. This case management staff is able to provide services through the Maternal Child Outreach program, the special Infant Mortality Reduction Initiative, and Cal Learn.

Sincerely,

Jason Dobbs

Jason Dobbs
Executive Director

ANY COUNTY SUPERINTENDENT OF SCHOOLS
JARED E SORENSON, Superintendent
8111 Middle Avenue, Anytown CA, 93652 (312) 888-4000

January 28, 2001

Mr. John Smith
Anytown Community Collaborative
234 Main Street
Anytown, CA 93652

Dear Mr. Smith:

The Anytown Child Development Center operated by the Office of the Any County Superintendent of Schools provides early intervention programs for disabled and non-disabled children who are birth to six years of age. In the past two years, the center has implemented a successful school-based and school-linked Healthy Start program. The Center is committed to early intervention and to restructuring the way that services are provided to children and their families.

Anytown Child Development Center, therefore, is committed to the Anytown Community Collaborative through active participation in the Coordinating Council and the provision of resources to the project. The Office of the Any County Superintendent of Schools will provide the Anytown Child Development Center facility to serve as the "home site" to the Anytown Community Collaborative activities and projects designated by the Coordinating Council. The office will redirect fifteen hours a week of a School Social Worker and fifteen hours a week of a Bilingual/Bicultural Instructional Aide toward the efforts of the Family Services Coordination Team in working with special needs children and their families. Two staff members from the Anytown Child Development Center will serve as active participants on the Coordinating Council.

Anytown Child Development Center is committed to new relationships among service providers and community entities in the Anytown Community.

Sincerely,

Jared E. Sorenson

JARED E. SORENSON
County Superintendent of Schools

Maggie Joseph

Maggie Joseph, Director
Special Education Programs

ANY COUNTY PUBLIC HEALTH DEPARTMENT

Mitchell S. Dean, M.D., M.P.H.
Director of Public Health Services
Health Officer

PUBLIC HEALTH NURSING
Sandra Hill, PHN, M.P.H. Director
1692 Well Street
Anytown, CA 93652
(321) 888-7800

January 16, 2001

To: Anytown Community Collaborative

The Any County Public Health Department supports the efforts of the south Anytown Community Collaborative as a way of improving services (both accessibility and availability) to that community.

The monthly on site immunization clinic, which we provide, demonstrates our support. We also conduct a Child Health Clinic twice yearly at this site.

Best wishes for your continued success.

Sincerely,

Sandra Hill

Sandra Hill
Director of Public Health Nursing

SH/rj

JOB TRAINING RESOURCE

January 23, 2001

Community Collaborative Coordinating Council
234 Main Street
Anytown, CA 93652

Dear Council Members:

Job Training Resource (JTR) would like to express support for the Anytown Community Collaborative application to assist in a unified effort in empowering the lives of those in Anytown.

JTR is the Service Delivery Area entity administering Job Training Partnership Act (JTPA) funds in Any County. In administering JTPA programs, our agency provides employment and training services to eligible low income residents of the county. Many of our applicants are migrant or seasonal farm workers, families on public assistance, displaced workers and homeless individuals from the Anytown area. To assist in targeting that area many of these people are served through one of our satellite offices located at the Abel Sorenson Center. Services provided may include classroom training, (occupational, basic/remedial, ESL), on-the-job training, job search assistance, work experience, supportive services, etc.

It is through these continued efforts that JTR supports the Anytown Community Collaborative to assist individuals to learn skills, become stable, pursue careers, and become productive members of their communities.

Respectfully,

David South

David South
Director, JTR

DS/slm

DEPARTMENT OF CORRECTIONS
PAROLE & COMMUNITY SERVICES DIVISION
6000 Lakeside Drive
Anytown, CA 93652
(312) 888-9000

January 17, 2001

Anytown Community Collaborative
Coordinating Council
234 Main Street
Anytown, CA 93652

Dear Council Members:

The Department of Corrections-Parole & Community Services Division (P&CSD) of Anytown acknowledges the Anytown Community Collaborative for their efforts to deliver vital and much needed services to the residents of the Anytown area.

P&CSD - Anytown would also like to take this opportunity to extend our support through networking with your agency to enhance the overall effectiveness of services delivered.

Many of the individuals that the Anytown Community Collaborative will come in contact with will undoubtedly be the very same individuals that are involved with P&CSD. Therefore, it is essential for integrated networking and concise communication through the deployment of staff and other resources available.

Through such efforts, it is our sincere hope that a significant and positive impact will be made thus strengthening the lives of those we serve while creating a better future in their community.

Sincerely,

Thomas Corson

Thomas Corson
Chief

Case Management Forms Checklist

Referral for Services	Date Competed:	
	Sent To Data Collection?	
Family Intake / Assessment Form (Pre-test)	Date Competed:	
	Sent To Data Collection?	
Family Intake / Assessment Form (Post-test)	Date Competed:	
	Sent To Data Collection?	
Feedback to Referral Party	Date Competed:	
Release of Information	Date Competed:	
Family Profile	Date Competed:	
Family Intervention Plan	*SMART?	
	Date Competed:	
	Signed	
Immunization Records	Date Received:	
Quarterly Summary	Date Competed:	
Case Comments	Current?	
	Follows Plan?	

**Specific, Measurable, Achievable, Relevant, Time-Limited*

Referral for Services

Individual's Name:_____Date:_____DOB:_____Age:___

Home Address:_____ Phone: (H)_____ (W)_____

Parent/Guardian:_____Relationship:_____

Ethnicity:_____ Home Language:_____ Client Language:_____

(If student) School:_____ Teacher:_____ Grade:____

(If prenatal) LDP:____ EDC _____ #Pregnancies _____ #Living: _____ #Children in home:_____

Was Client notified of referral: _____Yes _____ No _____ N/A

Referred By:_____ Date:_____

Is this person or family receiving services from other agencies _____Yes _____No

Name of agencies:_____

CHECK ANY OF THE FOLLOWING THAT DESCRIBES THE PERSON BEING REFERRED

	SCHOOL PERFORMANCE		MEDICAL/PHYSICAL		PUBLIC SERVICES NEEDED
	Doesn't complete assignments		Poor personal hygiene		Food
	Lacks motivation/uninterested in school		Pregnancy		Clothing
	Frequent tardiness		Neglect		Housing
	Poor attendance		Suspected physical/emotional abuse		Legal/Immigration
	Sleeps in class		Has dental needs		Employment
	Reading skills below grade level		Has vision needs		Tutoring
	Math skills below level		Has hearing needs		Substance abuse/alcohol education
	Defiant to rules		Known medical problems		Health care
	Oral/written skill below grade level		CHDP follow up		Parent classes
	Short attention span		Nutritional problems		Family counseling
	Other (explain)		Other (explain)		Child care
					Transportation
					Mental health service

	BEHAVIOR		HOME ENVIRONMENT
	Anxious/nervous		Unstable living arrangements
	Withdrawn or shy		Cares for younger siblings
	Inattentive		Problems with siblings
	Defiant towards authority		Problems with spouse
	Disrupts others		Problems with children
	Aggressive/short temper		Inconsistent discipline
	Steals		Death of a significant other
	Lies		Addition to family (sibling, etc.)
	Low self esteem		Divorce or separation
	Doesn't take responsibility for own actions		Not living with biological family
	Erratic behavior		Incarceration of family members
	Depression		Substance/alcohol abuse by family
	Suspected alcohol or substance abuse		Unemployment issues in the home
	Other (explain)		Other (explain)

STAFF INVOLVEMENT:_____
_____

OTHER(S): _____
_____

BRIEF DESCRIPTION OF PROBLEM:_____
_____
_____
_____
_____
_____

Is the person willing to be contacted by a Family Advocate for help: ___ YES ___NO ___N/A

ACTION TAKEN ON REFERRAL:

Date:_____ Time:_____ Contacted by:_____

_____
Signature of Intake Person

Family Intervention Plan

Initial Date _____
Review Date _____

Family Name: _____

Presenting Problem: _____

Long Term Goals	Interventions	By Whom	Outcome
By:_____ *(date)*			
Short Term Goals	**Interventions**	**By Whom**	**Outcome**
By:_____ *(date)*			

_____
Family Advocate

Family Advocate's observations and feelings which describe the family and their challenges or struggles.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Methods of Intervention

What are you going to do to assist the parent in the problem solving process and what obstacles must be overcome in order to successfully implement the case plan?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Frequency of Services/Contacts: Projected length of service - 1 yr.)

___ Weekly ___ Bi-Weekly ___ Monthly ___ 3 month ___ 6 month ___9 month ___ 12 month

Review 90 Days From:_____
(month/day/year)

Family Advocate's Contact Notes

DATE	COMMENTS

Quarterly Summary of Service Activities

Initial Date _____
3-Mo. Review Date _____

Family_____

_____ _____
Family Advocate Family Services Facilitator

FAMILY INTAKE/ASSESSMENT FORM

Form Completed By:

Phone Number:

Site ID:	First Date of Intake:	Secondary contact (someone, other than household member, who will know family's whereabouts if they move):
Location#:		
Index Child Name:		Name:
Phone#:		Phone#:
Address:		Address:
City, Zip:		City, Zip:

Who lives in child's household? Indicate relationship to child. (circle all that apply)

☐ 1 Alone ☐ 4 Foster Parent ☐ 7 Significant other of child ☐ 10 Siblings

☐ 2 Mother/Stepmother ☐ 5 Grandparent ☐ 8 Spouse of child ☐ 11 Children of parenting teen

☐ 3 Father/Stepfather ☐ 6 Aunt or Uncle ☐ 9 Other adult ☐ 12 Other children

Date of birth of youngest child of parenting teen: ____/____/____

Total people in household: Total children under 6: Total children aged 6-18:

HOUSEHOLD ISSUES

Family Needs Now:	Yes	No	DK
Clothing	1	2	8
Food	1	2	8
Transportation	1	2	8
Emergency funds	1	2	8
Child care	1	2	8

Family Receives Now:	Yes	No	DK
AFDC	1	2	8
Medi-Cal	1	2	8
WIC	1	2	8
Social Security	1	2	8
Food Stamps	1	2	8
CHDP	1	2	8

Out of home child placement

Yes	No	DK
1	2	8

Housing is: (circle only one)

1 Owned 5 Sheltered

2 Rented 6 Homeless

3 Employer provided 7 Other:

4 Group home

Utilities functioning now:

Heat	1	2	8
Electric	1	2	8
Water	1	2	8
Telephone	1	2	8

Eviction/foreclosure pending:

Yes	No	DK
1	2	8

Employment (Adults and high school-aged children only) (circle all that apply)	Index Child	Household Member 1	Household Member 2	Household Member 3	Household Member 4	Household Member 5
	1 Not working	1 Not working	1 Not working	1 Not working	1 Not working	1 Not working
	2 Seeking work	2 Seeking work	2 Seeking work	2 Seeking work	2 Seeking work	2 Seeking work
	3 Job traing	3 Job traing	3 Job traing	3 Job traing	3 Job traing	3 Job traing
	4 Part-time	4 Part-time	4 Part-time	4 Part-time	4 Part-time	4 Part-time
	5 Full Time	5 Full Time	5 Full Time	5 Full Time	5 Full Time	5 Full Time
	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal
	8 Unknown	8 Unknown	8 Unknown	8 Unknown	8 Unknown	8 Unknown

FAMILY INTAKE/ASSESSMENT FORM (continued)

DEMOGRAPHICS OF HOUSEHOLD MEMBERS INVOLVED IN SERVICES												
	Index Child		**Household Member 1**		**Household Member 2**		**Household Member 3**		**Household Member 4**		**Household Member 5**	
Name:												
Relationship to Index Child Code: (use codes from pg 1)												
Social Security # (optional):												
Medi-Cal # (if available):												
Client ID (e.g., Case ID; Student ID):												
BirthDate: Month/Day/Year												
County of Birth (optional)												
State of Birth (optional)												
Nation of Birth (optional)												
Gender:	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female
English Profieciency (for age & older)	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited
Mother's last name (optional):												
Mother's maiden name (optional):												

FAMILY INTAKE/ASSESSMENT FORM (continued)

Ethnic Background	Index Child	Household Member 1	Household Member 2	Household Member 3	Household Member 4	Household Member 5
	10 American Indian, Eskimo or Aleut (Native American) 20 Asian 21 Chinese 22 Filipino 23 Japanese 24 Asian Indian 25 Korean 26 Vietnamese 27 Cambodian 28 Hmong 29 Laotian 71 Thai 72 Other Asian 50 Black (African American) 60 White	10 American Indian, Eskimo or Aleut (Native American) 20 Asian 21 Chinese 22 Filipino 23 Japanese 24 Asian Indian 25 Korean 26 Vietnamese 27 Cambodian 28 Hmong 29 Laotian 71 Thai 72 Other Asian 50 Black (African American) 60 White	10 American Indian, Eskimo or Aleut (Native American) 20 Asian 21 Chinese 22 Filipino 23 Japanese 24 Asian Indian 25 Korean 26 Vietnamese 27 Cambodian 28 Hmong 29 Laotian 71 Thai 72 Other Asian 50 Black (African American) 60 White	10 American Indian, Eskimo or Aleut (Native American) 20 Asian 21 Chinese 22 Filipino 23 Japanese 24 Asian Indian 25 Korean 26 Vietnamese 27 Cambodian 28 Hmong 29 Laotian 71 Thai 72 Other Asian 50 Black (African American) 60 White	10 American Indian, Eskimo or Aleut (Native American) 20 Asian 21 Chinese 22 Filipino 23 Japanese 24 Asian Indian 25 Korean 26 Vietnamese 27 Cambodian 28 Hmong 29 Laotian 71 Thai 72 Other Asian 50 Black (African American) 60 White	10 American Indian, Eskimo or Aleut (Native American) 20 Asian 21 Chinese 22 Filipino 23 Japanese 24 Asian Indian 25 Korean 26 Vietnamese 27 Cambodian 28 Hmong 29 Laotian 71 Thai 72 Other Asian 50 Black (African American) 60 White
Education Status (circle all that apply)	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:
If not enrolled, education completed (00=No school, Pre K, K, 1-13, 13=some college, 14=college grad						
If enrolled now, current grade level (Pre-K, K, 1-12, 13=College)						
Did child attend the same school last year?	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No
If different school, name of K-12, school attended last June, include City & State						
After-school provisions for children ages 6-12 (circle only one)	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:

FAMILY INTAKE/ASSESSMENT FORM

Form Completed By:

Phone Number:

Site ID:	First Date of Intake:	Secondary contact (someone, other than household member, who will know family's whereabouts if they move):
Location#:		
Index Child Name:		Name:
Phone#:		Phone#:
Address:		Address:
City, Zip:		City, Zip:

Who lives in child's household? Indicate relationship to child. (circle all that apply)

☐ 1 Alone ☐ 4 Foster Parent ☐ 7 Significant other of child ☐ 10 Siblings

☐ 2 Mother/Stepmother ☐ 5 Grandparent ☐ 8 Spouse of child ☐ 11 Children of parenting teen

☐ 3 Father/Stepfather ☐ 6 Aunt or Uncle ☐ 9 Other adult ☐ 12 Other children

Date of birth of youngest child of parenting teen: ____/____/____

Total people in household: Total children under 6: Total children aged 6-18:

HOUSEHOLD ISSUES

Family Needs Now:	Yes	No	DK
Clothing	1	2	8
Food	1	2	8
Transportation	1	2	8
Emergency funds	1	2	8
Child care	1	2	8

Family Receives Now:	Yes	No	DK
AFDC	1	2	8
Medi-Cal	1	2	8
WIC	1	2	8
Social Security	1	2	8
Food Stamps	1	2	8
CHDP	1	2	8

Out of home child placement

Yes	No	DK
1	2	8

Housing is: (circle only one)

1 Owned 5 Sheltered

2 Rented 6 Homeless

3 Employer provided 7 Other:

4 Group home

Utilities functioning now:

Heat	1	2	8
Electric	1	2	8
Water	1	2	8
Telephone	1	2	8

Eviction/foreclosure pending:

Yes	No	DK
1	2	8

Employment (Adults and high school-aged children only) (circle all that apply)	Index Child	Household Member 1	Household Member 2	Household Member 3	Household Member 4	Household Member 5
	1 Not working	1 Not working	1 Not working	1 Not working	1 Not working	1 Not working
	2 Seeking work	2 Seeking work	2 Seeking work	2 Seeking work	2 Seeking work	2 Seeking work
	3 Job traing	3 Job traing	3 Job traing	3 Job traing	3 Job traing	3 Job traing
	4 Part-time	4 Part-time	4 Part-time	4 Part-time	4 Part-time	4 Part-time
	5 Full Time	5 Full Time	5 Full Time	5 Full Time	5 Full Time	5 Full Time
	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal	6 Temporary/seasonal
	8 Unknown	8 Unknown	8 Unknown	8 Unknown	8 Unknown	8 Unknown

FAMILY INTAKE/ASSESSMENT FORM (continued)

DEMOGRAPHICS OF HOUSEHOLD MEMBERS INVOLVED IN SERVICES												
	Index Child		**Household Member 1**		**Household Member 2**		**Household Member 3**		**Household Member 4**		**Household Member 5**	
Name:												
Relationship to Index Child Code: (use codes from pg 1)												
Social Security # (optional):												
Medi-Cal # (if available):												
Client ID (e.g., Case ID; Student ID):												
BirthDate: Month/Day/Year												
County of Birth (optional)												
State of Birth (optional)												
Nation of Birth (optional)												
Gender:	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female	1 Male	2 Female
English Profieciency (for age & older)	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited	1 Fluent	2 Limited
Mother's last name (optional):												
Mother's maiden name (optional):												

FAMILY INTAKE/ASSESSMENT FORM (continued)

Ethnic Background	Index Child	Household Member 1	Household Member 2	Household Member 3	Household Member 4	Household Member 5
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Education Status (circle all that apply)	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:	0 Too young for school 1 Enrolled now 2 High school grad/GED 3 Dropped out 4 Attended/grad college 5 Other:
If not enrolled, education completed (00=No school, Pre K, K, 1-13, 13=some college, 14=college grad						
If enrolled now, current grade level (Pre-K, K, 1-12, 13=College)						
Did child attend the same school last year?	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No
If different school, name of K-12, school attended last June, include City & State						
After-school provisions for children ages 6-12 (circle only one)	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:	1 Not cared for by person older than 12 years 2 Cared for by person older than 12 years 3 Organized Program 4 Other:

Family Profile

I. Family composition:

_____
_____

A. Parents: Mother/Father Step Mother/Step Father Other_____
Age:_____Date of Birth_____
Ethnicity_____
Language _____
Sex: ___Male ___ Female
Other adults living in the home: _____

B. Children: _____
_____
_____

C. Marital Status: _____Means of Support: _____
_____
_____

D. Support System: (Family, Friends, Church, etc.) _____
_____
_____

II. Purpose for the Referral: (Presenting Problem, Family Needs, etc.)

_____
_____

III. Brief Family History:

_____
_____

IV. Agency Involvement

Agency Name	Contact Person (S.W., P.O., Other)

V. Family Resources

Financial:
Employment _____ SSI _____
Public Assistance _____ Other _____

Transportation:
Car _____ Bus _____ Friend _____ Other _____

Medical:
Private _____ Medi-Cal _____ Other _____

Support Systems:
Family _____ Friends _____ Church _____ Other _____

VI. Parent Statement

1. Short Term Goals:

2. Long Term Goals:

VII. Case Management Team Recommendations:

Date of Review: _____
90 Day Date: _____

TERMINATION FORM

Project:_____Date:_____

Client Name:_____

I. What is the Disposition of this case?

Project staff determined there was little or no evidence of need for services.

Family refused services.

Family withdrew from services. Reason:

Services completed.

Family has not followed through with plan for services.

II. Do you feel that the goals of treatment/services have been accomplished?

Yes

No

Not Applicable

IF YES: Please describe the positive changes you noted in the child, the family, and/or the home environment.

IF NO: What were the major obstacles impeding the realization of the goals?

_____
_____
_____
_____

Please list all of the agencies, services, and resources to which you referred this case during the time of services.

_____ _____
_____ _____
_____ _____
_____ _____

SAMPLE LETTER OF INVITATION

Anytown Community Collaborative 234 Main Street Anytown, CA 93562 312-888-9900

January 5, 2001

Jennifer Jacks
Any County Mental Health-Children's Services
P.O. Box 6000
Anytown, CA 93652

Dear Jennifer:

The Anytown Community Collaborative Family Advocate Service Team would like to invite you to participate in the ACC Multi-Disciplinary Team (MDT) Meeting on Tuesday, February 18, 2001, from 1:30 to 2:30 p.m. The meeting will be held at the Anytown Community Center, 234 Main Street.

Through Anytown's integrated case management system, family advocates are able to assist families in need by linking them to the necessary resources that will assist them in overcoming barriers as they work toward their goal of self-sufficiency. The concept of developing an integrated case management system was seen as a way of enhancing services to families without duplicating efforts. A multitude of agencies are able to work together to stretch their resources; therefore, as dollars continue to decrease, agencies are able to continue to find ways to empower and enhance the lives of children and their families with less duplication and greater cost efficiency to service providers.

The primary function of the MDT will be to listen to presentations from the family advocates about individuals and/or family situations that they have been unable to resolve and to provide direction to the advocates on case plan development. A second function of this group will be to provide information to improve the skills and networking of the family advocates of ACC and to develop strategies to overcome obstacles that may exist in providing the individuals with the resources needed to meet their goals.

The services that you provide are important to the families we are serving. Your participation at our monthly MDT meetings will benefit our families, their children and the community. The meeting will also provide a strong network for you and your agency as you seek ways to collaborate.

If you are unable to attend, please send a representative from your agency. Thank you for your time and consideration.

Sincerely,

John Smith
Facilitating Coordinator

Sample
INSTRUCTIONS FOR COMPLETING EVALUATION FORMS

Family/Client Intake Form

This form was taken directly from the SRI Healthy Start state-wide evaluation program. Since all agencies require the collection of client data, we chose to use the Healthy Start form not only because it is well-designed and comprehensive, but also because some Neighborhood Partnership sites are also Healthy Start sites and are already required to use them.

All items on the intake/assessment form should be completed before sending the form to the evaluation consultant. If the information is not available because the client does not know the answer or refuses to give the answer, use the following codes to indicate these responses:

DK Use this code for any item on the intake form when the client does not know the answer. This code should only used when the client has been asked the question but indicates that he/she does not know the answer. If the family advocate does not know the answer because the question was not asked of the client, leave the item blank.

R Use this code for any item on the intake form when the client refuses to answer the question.

ITEM INSTRUCTIONS	
Form completed by	Name of family advocate completing the intake form (PLEASE PRINT). This information will not be used for analysis. It simply identifies a person to contact if there are questions about the form.
Contact at	Phone number where the family advocate can be reached if clarification is needed.
Site ID	FOR HEALTHY START OPERATIONAL GRANTEES ONLY. A 3-digit number unique to each site was assigned to each SB62O operational grantee either by the state or by SRI. Use this number if you are a Healthy Start site.
Location #	Healthy Start Operational Grantees: complete as directed by SRI. All others: give the name of the school attended by the referred child.
First Date of Intake	The date the intake process for a client begins. The family advocate has 30 days or three home visits (whichever comes first) from this date to complete the form.
Index Child Name	Print full name of index child. The index child is usually the child attending the Neighborhood Partnership school who is the reason the family is involved in integrated services. For example, the child is referred to the Student Assistance Team for services because he/she is having problems in school, or a mother goes to a health clinic because of a particular child's health problems. The SAT or the clinic refer the family to Neighborhood Partnership. The index child should be a student enrolled in a Neighborhood Partnership school site. If there are several children in the family who could be considered the index child, any one of them can be chosen as the index child. If there are no students in the family enrolled in a Neighborhood Partnership school, choose a school-age child. If there are no school-age children, choose a younger child. Designating an index child is a way to determine relationships among the household members listed on this form. If you are serving a client that has no children ages 0-18, write the client's last name followed by "NO CHILD" (e.g., Valdes NO CHILD). For the item "Who lives in the index child's household," relationships should be in reference to Household Member 1 (e.g., if the clients household consists of a woman, her 20-year old son and her elderly mother, select one of these individuals as Household Member 1 and circle the codes indicating the relationship of the other household members to that individual). When completing the rest of the form, leave the Index Child column blank.
Index child address and phone	Address and phone of child's primary residence.
Another phone number	If another number is available (e.g., mother's work), include it here.
Secondary contact	These questions are included to help locate clients who move. The family advocate might ask, “Is there someone, other than a household member, who will know where you are if you move?"
Who lives in household	Circle all numbers that correspond to people currently living in the index child's or secondary youth's household. "Currently living in the household" means usually spending at least 5 nights a week there. The relationship codes refer to the household member's relationship to the index child. For families living in multiple family residences (e.g., three families living in a single-family home), include all other residents if the client is willing to do so.
Parenting teen	This should be completed only if there is a parenting teen in the household. Enter the date of birth of the teen's youngest child. If more than one parenting teen is in the household, enter the date of birth of the youngest child.

Total people	Record the total number of people currently living in the index child's household, including non-relatives, and the total number of children, including the index child, in the specified age groups.
HOUSEHOLD ISSUES	This section requests information about the household as a whole. The family advocate might want to say, "Our program offers many kinds of help. My next few questions are about whether you or anyone in your household needs help in some of these areas." Make sure to indicate a response (yes, no, or don't know) for every item. Examples are given below of the way the family advocate might phrase his/her questions:
Family Needs Now:	
Clothing	"Does your family/household have enough clothing?"
Food	"Do you ever run out of food for your family/household because you don't have money to pay for it?"
Transportation	"Can you and other household members usually get around to the places you need to go?"
Emergency funds	"Does your family/household have enough money right now to buy what you need and pay bills?"
Child care	"Do you have someone to take care of the children when you can't be home?"
Out of home child	"Are any children in your family living outside the home, like in foster care, or under the care of the state?"
Family receives now	"Does your family/household get help from: * AFDC (Aid to Families with Dependent Children) * Medi-Cal * WIC (Women, Infants and Children) * Social Security * Food Stamps * CHDP (Child Health & Disability Prevention)?
State of Birth	OPTIONAL. Indicate the state of birth for each household member born in the US.
Nation of Birth	OPTIONAL. Indicate the country in which each household member was born.
Gender	For every household member, indicate whether the household member is male or female. (Do not assume that the gender is obvious because of the client's name.)
English Proficiency	Ask only about household members age 2 or older. "How well does [NAME] speak and understand English?"
Mother's Last Name	OPTIONAL
Mother's Maiden Name	OPTIONAL
Ethnic Background	Have the client(s) indicate the ethnic background of each household member included on the intake form. Circle only one category for each individual. If the client is unable to select one of the subcategories for Asian or Hispanic, then circle the broader category.
Education Status	"Are you going to school now?" If not currently enrolled, ask whether the client graduated, earned GED, dropped out, etc. Enter the grade level completed.
Current School	For children currently enrolled in grades K-12, ask name of current school.
Did child attend...	Indicate whether the child attended the same school the previous year. If same school, skip the next item. If different school, ask the next item.
If different school	Because the child might have attended several schools last year, indicate the name and location of the school the child attended at the end of the last school year.
After-school care	Ask for all children ages 6-12: "Who usually looks after [NAME] after school?" Circle one response only. If child is in an organized after-school program, circle 3. If child is alone or with younger siblings, circle 1. If child is with someone older than 12, e.g., older sibling, mother, sitter, circle 2. If care varies by day, probe for "usually" or "most frequently". If school is not in session (e.g., closed during the summer), ask about child care provisions during the month just before school closed.
Housing is	If the intake worker knows that the client is homeless or living in a shelter or group home, circle the correct response without asking about housing. Otherwise the family advocate might ask: "Do you own or rent your home?" Circle 3 if the client is a migrant worker who does not pay rent to farm owner or if client is living in employer's home (e.g., as a child care provider). If client lives in a group home, circle code 4.
Eviction/foreclosure	Determine whether eviction or foreclosure is pending.
Utilities functioning	"Do your lights, heat, and water all work now?" If No, "Which ones are turned off?" "Do you have a phone?"
DEMOGRAPHICS	The information on the rest of the Family Intake Form should be collected for each person in the household who might be included in receiving services from or through the site. The family advocate should include on the Intake Form all household members who could benefit from services offered. This can be the joint decision of the family advocate and client. The site may include family members who have an out-of-home placement who will be involved in services

	(e.g., a child in a residential program who will be involved in family counseling).
Name	PRINT the first and last name of each household member who will be included on the form.
Relationship to IC	This information will be used to describe the configuration of the household receiving services. Use the codes from the question about household members (e.g., enter 2 for mother and 3 for father).
Social Security #	Optional.
MediCal Number	If the individual has a MediCal number, it should be entered here.
Client ID #	FOR HEALTHY START SITES ONLY. Follow SRI instructions.
Birth Date	Month, day, and year on which the household member was born. If an adult prefers not to give a birthdate, enter 01/01/11 to indicate that they are over 18.
County of Birth	OPTIONAL. Indicate the county of birth for each household member born in the US.
Employment	Ask of adults and high-school aged children only. Circle all that apply. The family advocate might ask: "Is anyone working for pay now? Who?" Ask if employment is part-time or full-time (fulltime is 35 or more hours per week) and if it is permanent or temporary/seasonal. For those who are not working, ask: "Is anyone looking for work or in a job training program? Who?" If they are seeking employment and/or in a job training program, circle the appropriate responses.

INTERCEPT INTERVIEWS
Survey On Community Collaborative Awareness

The Anytown Community Collaborative Evaluation Team wants to know how aware you are about the work/services being provided in this neighborhood. We will use these findings to plan future work/services for families. This survey takes about three minutes to complete and it is completely confidential. Thank you for your participation.

---

1. Do you see children and families from this neighborhood in need?

   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

2. Can you name three (3) services available to them? If no, go to #3.

   _____
   _____
   _____

3. Do you see more parent involvement in either the school or in the neighborhood than you used to?

   ☐ None ☐ Rarely ☐ Not Sure ☐Some ☐ A Lot

4. Have you ever heard of The Anytown Community Collaborative before today?

   ☐ Never ☐ At least once ☐ 2-3 Times ☐ A Lot of Times

---

1. Your Gender (Check One) ☐ Male ☐ Female

2. How do you define Your Ethnicity? (Check One)

   ☐ White/Caucasian ☐ Black/African-American ☐ Hispanic/Latino ☐ American Indian
   ☐ Asian/Pacific Islander (please specify)_____
   ☐ Other (please specify)_____

3. Your Occupation _____

4. Do you live in this neighborhood? (Check One) ☐ Yes ☐ No

5. How long have you been involved with this school? _____Years _____Months

6. Are you: ☐ Parent ☐ Grandparent ☐ Legal Guardian ☐ Other

Thank you for taking the time to answer these questions.

Date _____ School_____

*Evaluator Name*_____
*Date*_____ *Time*_____

NATURALISTIC OBSERVATION OF EVENTS
FOR ANYTOWN COMMUNITY COLLABORATIVE

This instrument is designed to record the observation of an event, meeting, social, gathering, health fair, etc. conducted by Anytown Community Collaborative under natural conditions (without interruption or intervention by the evaluator at any time). The evaluator will record what they see, hear and perceive. As the evaluator, before you begin, you must establish a five (5) minute time frame when you will record verbatim what participants are saying. Record that time now: From_____ To_____

Event Description

Name of Event _____ Location_____

Type of Event: ☐ Meeting ☐ Clinic ☐ Workshop ☐ Conference ☐ Fair ☐ Social
☐ Other_____

Who is in charge of the Event?_____Affiliation_____

Event Structure: ☐ Meeting table ☐ Assembly Style ☐ Small Group Breakout ☐ Exhibitions
☐ Picnic Style ☐ other _____

Language: ☐ English ☐ Spanish ☐ Both ☐ other_____

Translation Provided: ☐ No ☐Yes, How_____

Printed Materials: If none check ☐ If yes, ☐ English ☐ Spanish ☐ Both ☐ Other_____

Demographics of the Participants

Estimated number of persons attending_____

Estimated number of Males_____ Females_____

Estimated age of persons under 18 years old_____ 19-24 years old_____ 25-34 years old_____
35-44 years old_____ 45-54 years old_____ 55 years and older_____

Estimated ethnic representation (by percentage) _____White/Caucasian _____Black/African-American
_____Hispanic/Latino _____American Indian _____Asian/Pacific Islander _____Other_____

Perceived group representation (by percentage) _____School Staff _____Parents _____Kids
_____Service Providers _____Clergy _____Local Business _____Law Enforcement
_____Local Government _____Neighborhood Residents _____other (Describe)

Ambience of the Event

Is the space comfortable? ☐ No ☐Yes_____
Describe How

_____

_____

Is there an agenda? ☐No ☐Yes In what language?_____

Is there active or passive participation on the part of persons attending?
Describe

_____

_____

_____

If decisions are made, who is making the decisions?
Describe

_____

_____

What is the atmosphere of the event?
Describe

_____

_____

Are accommodations made for any persons with a disability (hearing, speech, visual or physical)
Describe

_____

_____

Is child care provided? ☐ No ☐ Yes, By whom_____

Five (5) Minute Observation

In this section, the evaluator will record everything that is spoken verbatim and behaviors observed of the persons in attendance of the event. Please use notepad paper and write in pen. Clearly mark the name of the event, the location, the time begin and time end, your name and number the page(s). If you need to use proper names, please identify by title or role in the event, after the observation is complete. We will not use proper names in the final report. This is confidential information. Please staple your notes to this form. Do not make copies of your notes.

Observer's Debriefing

In this section, the evaluator will record, in your own words, any final comments about the event just observed.

_____

_____

_____

_____

_____

Evaluation
CASE REVIEWS

Ask the family advocate to select two cases: one he or she considers successful, and one that presented serious obstacles. Select a third case randomly. Have the family advocate walk through the case with you, making sure that the following issues are covered:

1. Name or number of the case:

2. Date of first referral:

3. Date of first contact:

4. Why was the family referred for services?

5. Describe your first contact with the family. Was it by phone or in person? How did you present yourself and the Community Collaborative?

6. Describe how you attempted to establish rapport (build trust) with the family. What did you say/do? How did the family respond?

7. At what point did you develop a case plan or set goals with the family? What did those goals include?

8. What kinds of services did you refer the family to? (Please name them.) How did the family respond? (Did you or they make the appointments? Did you provide transportation? Did the family follow through with the appointments?)

9. How did the family respond to the services they received? (Which did they seem to respond to the most? Which did they like the best/feel were the most useful? Were there any they disliked or felt that didn't really help them?)

10. About how often did you have contact with the family in the first three months of service? In the second three months? After that?

11. How far has the family come in meeting its goals, in your opinion? How far do you think they believe they have come?

12. What is your current relationship with the family?