Department of Children and Families

WEBINAR SCRIPT
FOR
JUNE 21, 22, 23, 24, 2011

SUPPORT FOR THE DEAF OR HARD-OF-HEARING
FORMS REVISIONS

Slide 2

Introduction

Hello, and Welcome to the Florida Department of Children and Families' on-line instructions for completing the **revised Customer Companion Communication Assessment and the related forms.** These forms are used to document the Department's efforts in providing the appropriate auxiliary aids and services to our customers and companions who are deaf or hard-of-hearing.

We encourage you to submit your questions and we will try to provide you with a response as we proceed through the presentation. Throughout the presentation, we will pause to respond to your questions. The questions we do not answer will be posted on our HR website beginning on **July 12th**. This will ensure that we have captured all questions from all of our Program Offices and our Contracted Client Services Providers.

Note: If you require special accommodations to participate in this training, please contact your Civil Rights Officer or ADA/Section 504 Coordinator.

Slide 3

During this presentation, the following forms will be discussed:

- Customer or Companion Communication Assessment Auxiliary Aid and Service Record
- Request for Free Communication Assistance or Waiver of Free Communication Assistance Form, ***this form was formerly referred to as the Waiver Form.***

- Customer / Companion Feedback Form, ***this is a new form that we are now introducing***

- Auxiliary Aid and Service Record Monthly Summary Report

All of these forms will be available for on-line completion in the near future.

Slide 4

The ***first*** form we will discuss is the ***Customer Companion Communication Assessment and Auxiliary Aid/Service Record.*** We initially begin using this form **June 2010,** and since then we have made **some minor, yet significant changes**. We feel these changes will ensure that we capture all the information needed to assist us in providing ***effective communication*** to our customers or companions who are deaf or hard-of-hearing. **It is important to note that this form must be completed first. This is the first form completed upon first contact with a customer or companion who is deaf or hard-of-hearing.**

The form must be completed for each Service Date, at the time of the contact so a proper assessment can be made. ***All*** information must be legible. ***All*** requested information must be included on the form. ***It is also recommended*** that you become familiar with its contents so you can readily identify the needs of our Customers.

Slide 5

The first part of the form we refer to as the Header

Region/Circuit/Institution:	**Program:**	**Subsection:**	
□ Customer □ Companion	**Date:**	**Time:**	**Case No.:**

Name:			
□ Deaf □ Hard-of-Hearing □ Deaf and Low Vision or Blind □ Hard-of-Hearing and Low Vision and Blind □ Deaf and Limited English Proficient □ Hard-of-Hearing and Limited English Proficient			
□ Scheduled Appointment □ Non-Scheduled Appointment □ No Show Date/Time:			
Name of Staff Completing Form:			

Indicate your Region/Circuit/Institution: For example:

- If you work in Pensacola, then you would enter: Northwest/Circuit 1;
- If you work at Florida State Hospital, then you will enter: Northwest/Circuit 2/FSH.

Or

- If you are a ***Contracted Client Services Provider*** in the Northwest Region you will enter: Northwest Region/Circuit Number/Provider name.

Program:

- For example: Family Safety, ACCESS, Mental Health, and so forth.

Subsection:

- For example: If your Program is ACCESS, then your Subsection may be – Call Center, Food Stamps, Medicaid, and so forth.

You must identify if the individual being served is a Customer or a Companion.

- A **Customer** is any individual seeking or receiving services from the Department or any of its' Contracted Client Services Providers.
- A **Companion** is any individual who communicates with the Department or any of its' Contracted Client Services Providers on behalf of the Customer.

Include their name, date and time of contact, and their case number. If your program does not use case numbers, you will need to create some other method of identification. Do not use their social security number, date of birth, or any other identifying data.

Check one box only to indicate if the individual is:

- **Deaf:** This is a person with profound permanent hearing loss.
- **Hard-of-Hearing**: This is a person with a low hearing loss.
- **Deaf and Low Vision or Blind**: This is a person who is deaf and also has any significant loss of vision or blindness.
- **Hard-of-Hearing and Low Vision or Blind:** This is a person who is hard-of-hearing and also has any significant loss of vision or blindness.
- **Deaf and Limited English Proficient**: This is a person who is deaf and also does not speak English, or has limited ability to read, speak, write, or understand English.
- **Hard-of-Hearing and Limited English Proficient**: This is a person who is hard-of-hearing and also does not speak English or has limited ability to read, speak, write, or understand English.

When making your selection in this box, **remember** – the Customer Companion Communication Assessment form is completed **only** for Customers or Companions who are **deaf or have some degree of hearing loss**. If a customer has no hearing loss, this form is not necessary, **regardless** of other disabilities the customer or companion may have **or** their inability to speak English. **The threshold is deaf or hard-of-hearing**, **otherwise this form is not to be completed.**

Next, you will identify if it is a **scheduled** appointment **or** if it is a **non-scheduled** appointment.

- If it is a **scheduled appointment**, remember, you must have a **certified** interpreter at the time of the scheduled appointment. If the interpreter fails to appear, staff shall take whatever additional actions are necessary to make a certified interpreter available to the Customer or Companion as soon as possible, but in no case later than **two (2) hours** after the scheduled appointment.

- If it is a **non-scheduled appointment or non-emergency situation**, you must provide a certified interpreter within **two hours** of the request, or at least by the next business day. **In emergency situations** an interpreter shall be made available as soon as possible, but in no case later than two (2) hours from the time the Customer or Companion requests an interpreter, whichever is earlier.
- Check the box if they are a **No Show** for their scheduled appointment.

Between the time an auxiliary aid and service is requested and the time it is made available, **continue** your attempts to communicate with the Customer or Companion, using whatever resources are available and appropriate. Keeping in mind that communication in writing is not always effective. Communication with a person who is deaf or hard-of-hearing is to be just as effective as the communication with a person who is not deaf or hard-of-hearing. Please refer to your Auxiliary Aids Plan for alternative auxiliary aids you can use.

It is very important to include the **name of the staff member** completing this assessment. Please print **or** ensure your handwriting is legible.

We have completed the header section. … PAUSE FOR QUESTIONS

Slide 6

Section 1: COMMUNICATION ASSESSMENT

□ **Initial** □ **Reassessment** □ **Subsequent Appointment**
Individual Communication Ability:
Nature, Length and Importance of Anticipated Communication Situation(s):
□ **Communication Plan for Multiple or Long-Term Visits Completed** □ **Not Applicable**
□ **Aid-Essential Communication Situation** □ **Non-Aid Essential Communication Situation**
Number of Person(s) Involved with Communication: **Name(s):**
Individual Health Status for Those Seeking Health Services:

Initial assessment:

- Check the box if this is an initial assessment.
- Initial assessments are done upon first contact with the customer or companion.

Reassessment:

- Check the box if this is a reassessment.
- In the event communication is not effective, or if the nature of the communication changes significantly after the initial assessment, staff shall conduct a reassessment to determine which appropriate auxiliary aid or service is necessary.

Subsequent Appointment: ***This is a new field on the form.*** Check the box if this is a follow-up contact or appointment.

Individual Communication Ability:

Always consult with the Customer or Companion when possible to determine which appropriate auxiliary aids and services are needed to ensure effective communication.

Nature, Length, and Importance of Anticipated Communication Situation (s):
This section should be completed with as much detail as possible. This will assist in determining whether the communication is aid-essential or non-aid essential.
[You may need to attach additional sheets detailing this information.]

Communication Plan
Check the box if a communication plan is being developed for multiple or long term visits. If no communication plan is being developed, then you will check the box marked **'Not applicable".** We will talk more about the communication plan shortly.

Aid-Essential Communication Situation
The term **Aid-Essential Communication Situation** shall mean any circumstance in which the importance, length, and complexity of the information being conveyed is such that the exchange of information between parties should be considered as **Aid-Essential**, meaning that the requested auxiliary aid or service is always provided.

Non-Aid Essential Communication Situation
The term **Non-Aid Essential Communication Situation** shall mean any circumstance in which the communication issue does not warrant provision of the auxiliary aid or service requested by the Customer or Companion. This allows DCF and its Contracted Client Services Providers the flexibility of using alternative methods to ensure effective communication.

Indicate the number of persons involved with the communication, along with their name.

Individual Health Status or Medical Concerns:

- Do not use electronic devices or equipment that may interfere with medical or monitoring equipment or which may otherwise constitute a threat to any Customer's medical condition.
- You should provide alternative means to effective communication and document this information in the medical chart or case file.

Slide 7

SECTION 2: AUXILIARY AID/SERVICE REQUESTED AND PROVIDED:

Type of Auxiliary Aid/Service Requested: **Date Requested:** **Time Requested:**
Nature of Auxiliary Aid/Service Provided: **Sign Language Interpreter: □ Certified Interpreter □ Qualified Staff □ Video Remote Interpretive Service □ Large Print** **□ Assistance Filling Out Forms □ Video Relay Services □ Florida Relay □ Written Material □ CART □ Other:**
Interpreter Service Status: □ Arrival Time: _____ □ Met Expectations of Client □ Met Expectations of Staff **□ No Show □ Cancellations**
Alternative Auxiliary Aid or Service Provided, including information on CD or Floppy Diskette, Audiotape, Braille, **Large Print of Translated Materials:**
Date and Time Provided:

Determine the type of Auxiliary Aid or Service being requested.

- Always document the date and time the auxiliary aid/service was requested.
- Document the nature or type of auxiliary aid and service provided.

For Example: If you use a Sign Language Interpreter – Indicate whether it was a certified interpreter, qualified staff interpreter or an interpreter provided via the Video Remote Interpretive Service, Video Relay Service or the Florida Relay Service. For further explanation of these services please refer to the Department's Statewide Auxiliary Aids Plan or your Region's Auxiliary Aids Plan.

Document **Interpreter Service Status** (This particular section is to be completed for Interpreters who are contracted by the Department or the Provider agency.)

- Indicate their Arrival Time.
- Check the box if they Met Expectations of Client
- Check the box if they Met Expectations of Staff

- Indicate if they were a **No Show** for the appointment **or** if they **cancelled** the appointment without providing you 24-Hours Notice.

- If an interpreter is a **no show**, staff will check the box accordingly, and document in section 3 what additional steps were taken to secure an interpreter as required. ***This may require attaching additional sheets to the form, documenting this process***.

Alternative Auxiliary Aids or Services Provided:

- Document the Alternative Aid and Service provided **and** indicate the date and time provided.
- In some circumstances staff may use alternative auxiliary aids and services, such as:
    - While waiting for the interpreter to arrive;
    - During non-scheduled appointments or emergency situations;
    - During non-aid essential communication situations;
    - During situations that may constitute a threat to the Customer or Companion's medical condition;
    - When requested by the Customer or Companion.

Again, keep in mind writing may not always be the most effective alternative method.

Remember, when providing alternative auxiliary aids and services, the **customer's preference takes priority** and the responsibility for ensuring effective communication **ALWAYS** remains with the Department or the Contracted Client Services Provider.

Slide 8

SECTION 3: ADDITIONAL SERVICES REQUIRED:

Was communication effective? □ Yes □ No If not, please explain why communication was not effective?
What action (s) was taken to ensure effective communication?

THIS IS A NEW SECTION ADDED TO THE FORM.

- Check the box if the **communication was effective**. H**ow do you determine if communication was effective?** Some examples might be: watching their facial expression, do they look puzzled or confused; appropriateness of their response; are they looking at the interpreter.
- If the **communication was not effective**, check the box and explain why the communication was not effective.

- When it is determined that the auxiliary aid and service provided was not effective, staff shall conduct a reassessment of the communication need to determine the appropriate alternative auxiliary aid.

- When staff has determined that the interpreter did not meet their expectations **or** the customer or companion's expectations, they will document in this section and indicate **what additional steps were taken by staff to ensure effective communication** with the Customer or Companion.

Slide 9

SECTION 4: REFERRAL AGENCY NOTIFICATION:

Name of Referral Agency:	
Date of Referral:	**Information Provided regarding Auxiliary Aid or Service Need(s):**

Whenever you refer a Customer for services outside your Department, Program, or Agency, you will need to complete this section.

1. The name of the referral agency must be provided.
2. **Advance notice** shall be provided to the referral agency, and the **date** the referral was made must be documented.
3. A statement must be included indicating that the referral agency was notified of the Auxiliary Aid and Service needs of the Customer or Companion.

Reminder: All steps shall be taken to ensure the confidentiality of information provided to a referral agency, pursuant to HIPAA. **Again**, the Referral agency must be provided all information regarding the Auxiliary Aid and Services needed by the Customer or Companion. This information must be provided in advance.

Slide 10

SECTION 5: DENIAL OF AUXILIARY AID/SERVICE BY THE DEPARTMENT:

Reason Requested Auxiliary Aid or Service Not Provided:
Denial Determination made by Regional Director/Circuit Administrator/Hospital Administrator or Designee or

the Contracted Client Services Provider or their Designee:	
Denial Date:	**Denial Time:**

- **If**, after conducting the assessment, a particular auxiliary aid or service requested by a Customer and/or Companion **will not** or **canno**t be provided, you will document the reason/s **the Requested Auxiliary Aid or Service was not provided.**
- **Only the Regional Director, Circuit Administrator, Hospital Administrator, or their designee, or the Contracted Client Services Provider Administrator or their designee, can** authorize the denial determination.

The person requesting the auxiliary aid or service shall be informed of the basis for the determination or denial, including:

- The date of the determination,
- The name and title of the staff member who made the determination, **and**
- The alternative auxiliary aid and service, if any, that the Department or Contracted Client Services Provider has decided to provide.

A denial of an auxiliary aid and service should only be done when it is a **non-aid essential communication situation**. Staff must still **ensure** that effective communication is achieved through whatever alternative means is provided.

Slide 11

COMMUNICATION PLAN FOR

FORSEEABLE MULTIPLE OR LONG-TERM VISITS

A **Communication Plan** is used in Mental Health Treatment Facilities, and other Direct

Client Service Facilities where customers reside for long periods of time and / or have numerous communications with personnel of varying length and complexity, which are determined as Aid-Essential Communication Situations.

Slide 12

Communication Plans are appropriate for:

- On-going investigations that will require repeated contacts,
- Customers receiving out-patient services for on-going treatment or counseling,
- Forensic facilities, **or**
- Other situations where you will have repeated contacts with the Customer or Companion.

Communication situations will differ from program to program, therefore you will need to identify all situations where your **program or agency** will have contact with a Customer or Companion and develop the plan on how you will communicate with them.

During follow-up visits or long term care, ***subsequent requests*** for the appropriate auxiliary aids and services by the Customer or Companion is not required because this is already captured in their communication plan; unless the method of communication has changed.

In each situation requiring an Auxiliary Aid **(whether Aid-Essential or Non-Aid Essential)**, you **must** identify in the communication plan **the name and title of the person responsible** for ensuring the auxiliary aid is provided.

You must also provide a **description of the information being communicated** to the customer or companion.

In the next couple of slides, you will see a list of communication situations that are often included in a communication plan. This list is not exhaustive and does not imply there are not other communication situations that may be **Aid-Essential** in a residential setting or during long-term visits.

Also, the list does not imply that each communication situation listed is an **Aid-Essential Communication Situation**. As we have stated earlier, some communication situations may be **Non-Aid Essential** therefore, the ultimate decision as to what measures to take rests with DCF personnel and DCF Contracted Client Services Providers, provided that they give primary consideration to the request of the Customer or Companion, **and** the method chosen results in effective communication.

The communication plan **needs to be updated quarterly** or as the communication situation changes.

Slide 13

COMMUNICATION SITUATIONS IN DEVELOPING A COMMUNICATION PLAN

□ **Intake/Interview:**

- During the **Provision** of a Customer's rights, informed consent, or permission for treatment
- During the **Determination** of eligibility for public benefits during the intake and review processes, and during completion of the initial Food Stamp Application
- During the **initial risk assessment**, if follow-up is indicated.

Slide 14

□ **Medical:**

- **Determination** of a Customer's medical, psychiatric, psychosocial, nutritional, and functional history or description of condition, ailment or injury
- **Determination** and explanation of a Customer's diagnosis or prognosis, and current condition;
- **Explanation** of procedures, tests, treatment options, or surgery
- **Explanation** of medications prescribed, such as dosage, instructions for how and when the medication is to be taken, possible side effects or food or drug interactions
- **Discussion** of treatment plans
- **Explanation** regarding follow-up treatments, therapies, test results, or recovery
- **During** visits by the Nurse

Slide 15

□ **Dental:**

- **Explanation** of procedures, tests, treatment options, or surgery
- **Explanation** of x-rays
- **Instructions** on self maintenance, i.e., brushing, flossing, etc.

Slide 16

□ **Mental Health:**

- **Provision** of psychological or psychiatric evaluations, group and individual therapy, counseling, and other therapeutic activities, including but not limited to grief counseling and crisis intervention
- **Provision** of discharge planning and discharge instructions

□ **Safety and Security:**

- **Communication** of relevant information prior to or as soon as possible after putting a person into restraints including but not limited to the purpose for using restraints and the conditions under which restraints will be removed
- **Communication** of emergency procedures, fire drills, etc.

Slide 17

□ **Programs:**

- **Presentation** of educational classes concerning DCF programs and/or other information related to treatment and case management plans;

□ **Off Campus trips or Recreational Activities:**

- Shopping
- Theme Parks

Slide 18

□ **Legal:**

- **Court proceedings**
- **Appeal Hearings**
- **Complaint and grievance process**
- **Investigation** by child protective services involving interviews, and home visits/inspections
- **Investigation** adult protective services involving interviews, and home visits/inspections

□ **Food Service / Dietician**

- **Discussion** of food restrictions and preferences

Slide 19

Examples:

Type of Aid: ASL Interpreter **Purpose of Aid**: GED Class – Instructions on preparation for upcoming test **Name and Title of Person Responsible for ensuring the Auxiliary Aid is provided:** John Q, Case Manager

Type of Aid: Note Cards with checklist **Purpose of Aid**: Dietary – Menu selection **Name and Title of Person Responsible for ensuring the Auxiliary Aid is provided:** Jane Q, Dietician

As a new requirement, the contact for each service provided shall be documented with the date and time in the Customer's chart or file on a contact log for Customers who are deaf or hard-of-hearing.

This will assist our residential or treatment facilities who have numerous contacts with our customers, sometimes as many as eight times per day. If a communication plan is developed then you will not have to complete an assessment each time you have contact with the customer. You will record the contact on a log, documenting the date, time, and auxiliary aid provided.

Slide 20

Signature of person completing form:	Date:
Signature of Customer or Companion:	Date:

The signature of person completing the form and the date, along with the signature of the customer or companion and the date is required.

The original Communication Assessment Auxiliary Aid Service Record and Communication Plan for on-going Services must be placed in the customer's medical chart or case file.

PAUSE FOR QUESTIONS

Slide 21

Now, we will move to our **second** form, which we have renamed as:

CUSTOMER OR COMPANION REQUEST FOR FREE COMMUNICATION ASSISTANCE OR WAIVER OF FREE COMMUNICATION ASSISTANCE. The Department and its Contracted Client Services Providers are required to provide **FREE** interpreters or other communication assistance, if needed. You will notice that we added a new box for the Customer or Companion to tell us **why they did not want a free interpreter**. **This form is always completed after the Communication Assessment.**

The Customer or Companion may:

1. Refuse free interpreter or other communication assistance.
2. Designate someone else to act as their interpreter.

Due to privacy and confidentiality concerns, potential emotional involvement, and other factors that may adversely affect the ability to facilitate communication, you should not **require or coerce** a family member, advocate or a friend of a Customer or Companion to interpret or facilitate communication between the Department and the Customer or Companion.

Under no circumstances should a minor be used as an interpreter.

In time-sensitive, life-threatening situations, staff may rely upon communication through a family member, advocate or friend until a qualified interpreter is obtained. Some customers will request an interpreter. It is very important that we do not ask or allow a companion or family member to act as the DCF interpreter. Personal friends or family may not always be objective or accurately interpret the information, they may be too emotionally attached or stressed, and confidentiality can become problematic.

Even if the customer insists on using their family member or friend as their interpreter, the Department is still required to provide “effective communication.” To ensure that the customer receives accurate information, we must provide a certified interpreter to observe the interpretation of the family member, friend or advocate. Also, anyone interpreting must be at least 18 years of age.

A Customer or Companion’s refusal **does not release the Department in its obligation** to

ensure effective communication. Simply stated, you may need to secure an interpreter or other auxiliary aids to ensure effective communication is occurring even if the customer or companion declines this service.

- If the Customer or Companion **declines** the offer to provide free auxiliary aids and services, staff shall complete and explain the appropriate form indicating the Customer or Companion's preferred method of communication.

- **Reasons** for declining free services may be for reasons separate from the quality of the provided interpreter. The client may decline free services if they feel the contracted interpreter or their agency have a conflict of interest or a trust or confidentiality concern. Contracting with a different interpreter or interpreter agency may resolve the conflict without the need to rely on a family member or friend to interpret. For example. If a Customer lives in a small community, the availability of an interpreter may be limited or they may be known to the Customer. You may need to obtain an interpreter from a neighboring county.

Slide 22

Staff must be prepared to secure the appropriate auxiliary aid or service in Aid-Essential Communication Situations and ensure that the Customer or Companion's preferred auxiliary aid or service is effective.

The form **must** be **signed and dated** by the Customer or Companion, Interpreter and Witness.

The form shall be attached to the Customer Companion Communication Assessment Auxiliary Aid and Service Record form and maintained in the Customer's file.

Slide 23

CUSTOMER / COMPANION FEEDBACK FORM

The Department of Children and Families is committed to providing excellent customer service. We value your opinion and request that you complete this short survey to assist us in evaluating and improving our services. While you are not required to respond, we thank you in advance for completing this survey**. The survey is ANONYMOUS; therefore, please do not provide your name or any other personal information UNLESS YOU WOULD LIKE TO BE CONTACTED**. Please complete the form and **submit it to the local office or mail to**: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 1, Room 110, Tallahassee, Florida 32399-0700.

DCF Direct Service Facilities and DCF Contracted Client Services Providers are required by the **Settlement Agreement** to collect data on the effectiveness and appropriateness of the auxiliary aid or services provided and the performance of the interpreter provided.

The Customer or Companion may choose whether to avail themselves of the opportunity to provide feedback **and may do so anonymously**.

For some Customers or Companions, limited written English proficiency may be a barrier to understanding or completing the form.

Staff shall offer assistance, including additional interpreter services, where necessary, for Customer or Companions to complete the feedback form.

The instructions require the feedback form to be mailed directly to Office of Civil Rights in Tallahassee. However, if a Customer or Companion completes and hands you the form,

you will place the form in a sealed **envelope** and **mail** or **forward** it to the Office of Civil Rights for them. You are not to retain any copies of the form.

Slide 24

AUXILIARY AID SERVICE RECORD MONTHLY SUMMARY REPORT

Region/Circuit/Institution/Contracted Client Services Provider: Contract No.	**Reporting Period:**	
Name of Program & Address:	**Subsection:**	
Single-Point-of-Contact: **Name of Person Completing Form:**	**Telephone:** **Telephone:**	**Date:**
SECTION I. CUSTOMERS		
SECTION II. COMPANIONS		
SECTION III. AUXILIARY AIDS AND SERVICES PROVIDED **(This section is completed by Contracted Client Services Providers only)**		
SECTION IV. Auxiliary Aids and Services Provided **(This section is completed by Department of Children and Families staff only)**		
SECTION V. COMMUNICATION PLANS **(This section is completed for Institutions and Residential Settings only)**		
SECTION VI. OUTSIDE AGENCY REFERRALS		
SECTION VII. COMMENTS/OBSERVATIONS		

The **fourth** and **final** form is the **Auxiliary Aid Service Record Monthly Summary Report.** We have made several improvements to this form to assist you better in capturing the required information. We have also provided **step by step** instructions to assist you in completing the form. This form is completed each month for all DCF Direct Client Service

Facilities and all Contracted Client Services Providers who have 15 or more employees and provide direct client services.

The Monthly Summary form is completed even if you have not had any contact with Customers or Companions who were Deaf or Hard-of-Hearing during the reporting period.

Slide 25

ADDITIONAL DOCUMENTS TO BE SUBMITTED WITH THE MONTHLY SUMMARY REPORT

NOTE: This is a new requirement and differs from what has been previously requested.

1) The **Customer or Companion Communication Assessment Form** in the following instances shall be attached to the Monthly Summary Report.
   - When the requested auxiliary aid or service **was not what was provided**
   - When the auxiliary aid or service **did not meet the expectation** of the customer, companion or staff
   - When the communication was **not found to be effective**
   - When the requested auxiliary aid or service **was denied**
   - When requested by the **Department** or **HHS**

2) The **Request For Free Communication Assistance or Waiver of Free Communication Assistance Form** that corresponds with the above accompanying form.

Slide 26

REPORTING DATES AND GUIDELINES

The Department and its Contracted Client Services Providers will begin using all of the revised forms mentioned in this presentation on July 1, 2011, for the period covering the month of June.

The reporting period will follow the guidelines listed below:

- Reporting period will cover the 1st through the 30th or the 31st of each month.
- DCF Single-Points-of-Contact reports are due to the Civil Rights Officer by the 10th of each month.

Slide 27

- Contracted Client Services Providers Single-Points-of-Contact **reports** are due to the Contract Manager by the 5th business day of each month, **or** as agreed upon between the Contract Manager and the provider.
- Contract Managers will submit reports to the Civil Rights Officers by the 15th of each month.

Slide 28

- Civil Rights Officers will submit reports to Headquarters Office of Civil Rights by the 20th of each month.
- Headquarters Office of Civil Rights will submit reports to the U.S. Department of Health and Human Services or the Independent Consultant by the 25th of each month.

These procedures are subject to change pending on-line reporting requirements.

Note: If the due date falls on a weekend or holiday, the report will be due the next business day.

Slide 29

COMPLIANCE IS NOT AN OPTION

Remember, **Compliance is not an Option.**

Our mission is to Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency. In doing so, we must be able to communicate effectively.

We **must** be in compliance with these guidelines and instructions to ensure that we are serving the people in the State of Florida in a fair and non-discriminatory manner.

As always, please contact your Single-Point-of-Contact, your ADA/Section504 Coordinator (Civil Rights Officer) or the Civil Rights Office for assistance.

We will leave the webinar lines open to allow you additional time to submit your questions. All questions and responses will be posted on our HR website beginning **July 12th**.

Thank you

Slide 30

DCF'S ADA/SECTION 504 COORDINATORS

- Headquarters/Northwood Centre - Pamela Thornton (850) 717-4567
- Florida State Hospital – Aldrin Sanders (850) 717-4566
- Northwest Region – Juan Cox (850) 717-4565
- Northeast Region – Richard Valentine (904) 723-2097
- Suncoast Region – Sharon Pimley-Fong (813) 558-5656
- Central Region – Pamela Phillips (407) 317-7552
- Southeast Region - Caroline Johnson (561) 837-5538
- Southern Region – Roosevelt Johnson (305) 377-5219