Coordinated Family Support (CFS) Vendor Monthly Reporting Form for CFS Pilot Implementation Incentive Payment

This report must be completed and submitted on a monthly basis by the CFS vendor to be eligible to receive the CFS Pilot Implementation Incentive Payments. The Report is due by the end-of-the-month following the Reporting Month (i.e., Reporting Month is March, form is due by the end of April). The CFS vendor electronically submits one report to each Regional Center to whom they are billing for CFS assessments and services. Some fields may not apply each month. Please indicate N/A for questions that do not apply for the month being reported.

1. Reporting Month
2. CFS Vendor Name
3. CFS Vendor Email
4. CFS Vendor Number
5. Regional Center

CFS Service Implementation

6. Total number of CFS personnel *at the beginning* of the Reporting Month
    a. Number of Staff
    b. Number of Supervisors

7. Total number of each Ethnicity of the *Staff at the beginning* of the Reporting Month:
    a. Hispanic / Latino or
    b. Not Hispanic / Latino
    c. Decline to state

    Number of each Ethnicity in the boxes below:

African American / Black		Hispanic / Latino	
American Indian / Alaskan Native		White	
Asian		Pacific Islander	
Native Hawaiian		Other	
		Declined to State	

8. Total number of each Ethnicity of the *Supervisors at the beginning* of the Reporting Month:
    a. Hispanic / Latino or
    b. Not Hispanic / Latino
    c. Decline to state

Number of each Ethnicity in the boxes below:

African American / Black		Hispanic / Latino	
American Indian / Alaskan Native		White	
Asian		Pacific Islander	
Native Hawaiian		Other	
		Declined to State	

9. Number of CFS personnel *added during* the Reporting Month for:
    a. Staff
    b. Supervisors

10. Number of each Ethnicity of *added Staff*:
    a. Hispanic
    b. Not Hispanic / Latino
    c. Decline to State

Number of each Ethnicity in the boxes below:

African American / Black		Hispanic / Latino	
American Indian / Alaskan Native		White	
Asian		Pacific Islander	
Native Hawaiian		Other	
		Declined to State	

11. Number of each Ethnicity of *added Supervisors*:
    a. Hispanic
    b. Not Hispanic / Latino
    c. Decline to State

Number of each Ethnicity in the boxes below:

African American / Black		Hispanic / Latino	
American Indian / Alaskan Native		White	
Asian		Pacific Islander	
Native Hawaiian		Other	
		Declined to State	

12. Number of languages other than English of *added Staff*:

Spanish		Vietnamese		Eastern Armenian	
ASL		Hmong		Western Armenian	
Chinese		Japanese		Decline to State	

13. Number of languages other than English of *added Supervisors*:

Spanish		Vietnamese		Eastern Armenian	
ASL		Hmong		Western Armenian	
Chinese		Japanese		Decline to State	

14. Number of training hours provided to meet CFS requirements for:
    a. Staff
    b. Supervisors

15. Topics of training provided to meet CFS requirements for Supervisors/Staff:

16. Identify the number of hours spent during the Reporting Month on the following activities:
    a. Staff recruitment
    b. Networking with other CFS provides to enrich delivery of services
    c. Attending CFS focuses group or webinars to gain knowledge
    d. Community outreach to provide CFS information

CFS Service Assessment

17. Average number of days between receiving the referral for assessment and the assessment being performed

18. Total number of hours billed for conducting assessments this Reporting Month
    a. Hours In-Person with the Participant
    b. Hours Networking with Others to Develop Plan
    c. Hours Documenting the Plan

19. Average number of days between when you received the authorization for services to when you began the CFS services

CFS Service Delivery

20. Were the majority of CFS services provided in the home?
    Yes No

21. Did you experience barriers in providing in the delivery of CFS services?
    Yes No
    a. If yes, please describe

22. Did you discover or develop best practices in the delivery of CFS services?
    Yes No
    a. If yes, please share your best practices

Direct Care Service Delivery

23. Did your CFS provider agency provide direct care during this reporting period?
    Yes No
    a. If yes, was direct care provided as a scheduled service?
        Yes No Direct care not provided
    b. If yes, was direct care provided as a back up service when a primary direct care service provider was not available?
        Yes No Direct care not provided
    c. If yes, was direct care provided by a staff the family has already been working with or staff they are familiar with?
        Yes No Direct care not provided

24. Average number of hours between when back-up direct care was needed (in accordance with criteria #7 in the Referral & Service Need Form) and when your CFS provider agency was able to provide the back-up direct care
    Direct care not provided

25. Did you experience barriers in providing direct care during this reporting period?
    Yes No Direct care not provided
    a. If yes, please describe

Form Completion and Verification

26. Person completing the Reporting Form
    a. Name
    b. Signature
    c. Date Completed
    d. Date Submitted

27. Date Reviewed by the Regional Center