

**Required Performance and Staffing Deliverables**

**for**

**Keeping Families Together**

**Effective Date: July 1, 2025**

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**Section I - Summary Program Description:**

The New Jersey Department of Children and Families’ (DCF) Division of Family and Community Partnerships’ (FCP), through its Office of Housing administers the Keeping Families Together (KFT) program to provide supportive housing to child welfare involved families who are experiencing homelessness or housing instability and other co-occurring challenges such as substance use disorders.

**Section II - Required Performance and Staffing Deliverables**

**NOTE: After reviewing the required deliverables listed below, the contractor must sign the statement at the bottom of this Section II to signify acceptance of all of them. Please submit an executed copy as a PDF document with the title heading: *Required Performance and Staffing Deliverables*.**

1. **Subject Matter -** **The below describes the needs the contractor must address in this program, the goals it must meet, and its prevention focus.**

1) **The need for this program as indicated by data regarding the health and human services issues and parent and community perceptions is:**

Housing instability impacts every aspect of health and well-being, and the connection between housing and social determinants of health is well-documented. On any given night in the U.S., over 1.2 million people experience homelessness. In New Jersey, over 10,000 people – in 7,800 households – experience homelessness on a given night. An estimated 17% of these households are families. When considering this data, it should be considered that many existing measures of housing need for families are significant underestimates. Factors contributing to this undercount, include tally methodologies and the fact that most precariously housed families live in “doubled-up” households and are often missed in formal housing need counts.

In addition to housing stability, many child-welfare involved families are also coping with other high-risk factors like substance use, mental health, domestic violence etc. In its report to Congress, the U.S. Department of Health and Human Services (DHHS) stated that between one-third and two-thirds of children in the child welfare system were affected by substance use disorders. An even higher percentage of parental substance use disorders are reported in cases with children in out-of-home placement. New Jersey statistics reflect a national trend that suggests between 40% and 80% of families involved with the child protective services system are affected to some degree by substance use (Hines, Lemon, Wyatt, & Merdinger, 2004; Semidei, Radel, & Nolan, 2001; Young, Boles, & Otero, 2007).

Family homelessness can have devastating effects on children, including high rates of family separation in the short-term. In the long-term, research shows that these challenges and poor outcomes tend to persist across generations. National research shows that, absent comprehensive interventions, these families often confront out-of-home placements for their children, family separation, ongoing substance use and mental health disorders, intergenerational poverty, and long-term homelessness.

To fully address the complex needs of families with recurring child welfare involvement, homelessness/housing instability, substance use disorders, and other co-occurring challenges such as mental illness, chronic medical conditions, and domestic violence, a longer-term comprehensive model (i.e., supportive housing) is needed. Supportive housing affords parents the ability to enhance their capacity to provide a safe and stable home for their children. Stable, affordable housing is also a crucial component of recovery for individuals with substance use disorders. Moreover, a growing body of research suggests that stabilizing individuals in supportive housing can reduce their use of expensive public crisis services such as emergency rooms, psychiatric hospitals, and jails.

KFT is a model of permanent supportive housing designed specifically for a subset of child welfare involved families who typically present with an array of co-occurring challenges including substance use disorders. To date, KFT has proven to be a promising practice in improving child well-being and decreasing child welfare involvement amongst the most vulnerable families. The goal of KFT is to improve outcomes for children by providing a secure place for families to live in an affordable, caring, supportive setting. Families are provided with the necessary support and guidance to manage their lives and improve well-being. Children benefit from supportive and stable communities, positive adult role models, and stronger family units.

The first KFT pilot was implemented in New York City from 2007-2010 and placed families with extensive histories of child welfare and homelessness into permanent supportive housing. The goal of the pilot was to determine whether supportive housing could prevent family separation, homelessness, and foster care placement among high-risk families. Families in the pilot received several supportive services, including a case manager to help them navigate the multiple services and systems in which they were involved. In addition, families participated in wellness self-management and parenting/family support groups. Keeping Families Together service providers also offered employment assistance, clinical assistance, and linkage to substance use disorder treatment.

KFT was evaluated by an independent research firm that measured indicators of family stability and child well-being. Almost all of the families in the pilot had either a past or current history of substance use. Half had a mental health diagnosis. All families had long and complex trauma histories. Despite their challenges, the KFT evaluation found that with supportive housing and dedicated case management, 90% of the pilot families remained in their homes, 61% of child welfare cases were closed in an average of 10 months after move-in, 100% of children returned to their families from foster care and remained with their families for at least 12 months or until the end of the pilot, abuse and neglect reports decreased dramatically, and roughly 63% had no further involvement with the child welfare system.

KFT’s results offer evidence that supportive housing can be an effective alternative to recurring child welfare system involvement and foster care placements among unstably housed families with high service needs. These positive outcomes, amongst families with complex challenges, suggest that supportive housing is a promising way of preventing abuse and ending traumatic foster care placements for families experiencing extreme poverty, disabling conditions, and instability.

More information on national child welfare supportive housing efforts can be found at: [Advancing Vulnerable Populations - CSH](https://www.csh.org/csh-solutions/advancing-vulnerable-populations/)

2) **The goals to be met by this program are:**

To keep families together by providing stable housing and evidence-based, trauma-informed support services to CP&P-involved families using a Housing First model.

3) **The prevention focus of this program:**

All program services are provided in accordance with the established program model as set forth in the [KFT-Program-Manual.pdf](https://www.nj.gov/dcf/documents/KFT-Program-Manual.pdf). Specific prevention focus of NJ KFT include the following:

Homelessness and Housing instability

Family Separation/Use of Foster Care

Recurrence of child welfare involvement

Recurrence of child maltreatment

1. **Target Population - The below describes the characteristics and demographics the contractor must ensure the program serves.**
2. **Age:** 0-23; Adults
3. **Grade:** N/A
4. **Gender:** All
5. **Marital Status**: Married; Divorced; Separated; Widowed; Civil Partnership; Single
6. **Parenting Status:** Biological
7. **Will the program initiative serve children of the primary service recipient?**

Yes

1. **DCF CP&P Status:**

**All eligible NJ KFT families must have the following CP&P Status and CHILD WELFARE INVOLVEMENT:**

One or more children at risk of out of home placement.

OR

One or more children in out of home placement with a case goal of reunification.

AND

A family deemed ready for reunification (indicators used to deem readiness may include frequent, regular, and high-quality parent-child visitation; completion and/or active participation in recommended services; the resolution of safety issues; etc.) with housing as the only remaining barrier to reunification.

1. **Descriptors of the primary service recipient to be served:**

Homeless; Housing Instability, Substance users who are addicted; Substance users who are in recovery; Substance users who do not require frequent inpatient treatment; Survivor of Domestic Violence; Survivor of Sexual Violence, Medical Illness, Mental Health Disorders, Developmentally Disabled

1. **Descriptors of the Family Members/Care Givers/Custodians of the primary service recipients also required to be served by this program initiative:**

Homeless; Housing Instability; Unemployed; Underemployed; Substance Users who are addicted; Substance users who are in recovery; Substance Users who do not require frequent inpatient treatment, Survivor of Domestic Violence; Survivor of Sexual Violence; Medical Illness, Mental Health Disorders, Developmentally Disabled

1. **Other populations/descriptors targeted and served by this program initiative:**

The target population for this program is a subset of high needs CP&P-involved families whose challenges with homelessness or housing instability have put their children at risk of out-of-home placement or have delayed reunification with children currently in out-of-home placement. Families appropriate for these KFT programs will also have other co-occurring needs such as a substance use disorder, medical and/or mental illness, or domestic violence.

The following indicators of need will be used to identify families eligible to participate in this KFT program:

**CHILD WELFARE INVOLVEMENT:**

One or more children at risk of out of home placement.

OR

One or more children in out of home placement with a case goal of reunification.

AND

A family deemed ready for reunification (indicators used to deem readiness may include frequent, regular, and high-quality parent-child visitation; completion and/or active participation in recommended services; the resolution of safety issues; etc.) with housing as the only remaining barrier to reunification.

Homelessness and/or Housing Instability (must meet at least 1 of the following)

• Family is sleeping on the street, in cars, or in other places not meant for human habitation

• Family has been homeless three or more times in the last 2 years

• Family is currently staying in a homeless shelter, transitional housing, or a residential treatment facility and will be homeless upon discharge

• Family has moved two or more times in the last 12 months

• Family is doubled up living with family/friends because they are unable to find suitable housing

• Family is unstably housed and imminently losing housing within five to seven days (e.g., eviction, discharge from hospital/institution, living in condemned housing, etc.)

**HIGH SERVICE NEEDS:**

KFT is designed to serve families with multiple needs and risk factors compromising their capacity to parent and remain housed. In addition to meeting the criteria above, families must meet at least two of the following:

• Primary caregiver has current or recent documented substance use disorder

• Primary caregiver has mental health diagnosis/disorder

• Child has mental or behavioral health challenges

• Child has developmental, learning, or physical disability

• Primary caregiver and/or child has a chronic medical condition

• History of or ongoing domestic violence

• Age of youngest child is under 6

• Primary caregiver has history of involvement with the child welfare system as a child/youth or other trauma history

1. **Activities - The below describes the activities this program initiative requires of the contractor, inclusive of how the target population will be identified and served, the direct services and service modalities that will be provided to the target population, and the professional development and training that will be required of, and provided to, the staff delivering those services.**

1) **The level of service increments for this program initiative:**

Contracted units of services are defined as the number of unduplicated families served by the program. For the contracted service area, the level of service, represents the minimum number of families to be served at one time.

2) **The frequency of these increments to be tracked:**

NJ KFT Providers will be responsible for collecting and reporting program data, using DCF approved data management processes, as follows:

* Baseline family survey; completed within 30 days of enrollment
* Utilization and Service Summary; completed quarterly
* Fidelity Assessments; completed bi-annually

Additional information regarding data collection tools and instruction can be found in the NJ [KFT-Program-Manual.pdf](https://www.nj.gov/dcf/documents/KFT-Program-Manual.pdf).

3) **Estimated Unduplicated Clients:**

4) **Estimated Unduplicated Families:**

5) **Is there a required referral process?** Yes.

6) **The referral process for enabling the target population to obtain the services of this program initiative:**

Families access NJ KFT services via referral from the DCF’s Division of Child Protection and Permanency (DCP&P) only. The initial referral process includes an eligibility screening completed by the DCF KFT program lead following referral. followed by pr and subsequently the implementing Provider and the DCP&P team.

7) **The rejection and termination parameters required for this program initiative:**

NJ KFT has the following exclusionary and termination criteria:

* NJ KFT caregivers/parents must be biological parents.
* The family declines NJ KFT services. While Provider partners make every effort to engage, motivate and support families in accessing services, NJ KFT is voluntary for families.
* NJ KFT utilizes housing subsidy and/or vouchers so households in violation of voucher regulations may be deemed ineligible and/or run the risk of termination and loss of housing.

Additional information regarding termination parameters and transition planning can be found in the NJ [KFT-Program-Manual.pdf](https://www.nj.gov/dcf/documents/KFT-Program-Manual.pdf).

8) **The direct services and activities required for this program initiative:**

The NJ KFT Program Model provides supportive housing and services. Once enrolled in the program, families have access to single and scattered site housing and a robust array of supportive services; including case planning with a NJ KFT team of clinical and case management staff and coordination of available community-based programming that include evidence-based and trauma-informed services.

The NJ KFT intervention and services are delivered across the following four (4) phases:

* Referral and Pre-Enrollment
* Intake and Enrollment
* Stabilization and Maintenance
* Moving On and Aftercare

NJ KFT service activities include the following:

* Case management (Housing and Support Services)
	+ NJ KFT Practitioners provide case management support beginning at intake and enrollment and continuing throughout the entirety of the family’s NJ KFT involvement. The practitioner leverages case management to support a range of activities aimed at maintaining housing stability and increasing well-being and family functioning while ensuring service provision is integrated (Arabo et al., 2016)
* Clinical Services (Individual and Group)
	+ NJ KFT clinical services are provided by licensed clinicians and designed to support families in meeting their clinical needs. These services are available on both the individual and family level, as needed; with varying frequency based on the identified needs, goals, and readiness for change.
* Concrete support (One-time financial support for security deposits, and other costs related to initial move in, along with limited non-emergency transportation); ***and***
* Linkage to community-based services
	+ There are instances where the needs of families must be met within the community. In these instances, the NJ KFT team connects families to community-based resources best suited to meet the identified needs, when these needs cannot be met within the scope of the intervention.

To support the delivery of the NJ KFT intervention, Providers are required to complete assessments and case planning in collaboration with families. These activities include but aren’t limited to:

* + Ongoing needs assessments using DCF approved standardized tools.
	+ Ongoing safety and risk evaluation using DCF approved standardized tools. As part of the service delivery to families whose CP&P case is closed, Providers shall complete safety and risk evaluations with the family using a validated tool. During the delivery of the intervention, Providers are expected to informally assess safety during every interaction. If safety concerns emerge, Providers should develop safety plans as needed and ensure families are connected to the supports necessary to keep children safely at home.
	+ Ongoing case planning: NJ KFT Practitioners work in partnership with families to develop a service plan that is informed by the family’s strengths, needs, and goals. The family’s progress towards goals is reassessed at regular intervals, at minimum bi-annually, to determine the need for service adjustments. This involves periodic plan reviews where family members, including youth, and the NJ KFT team evaluates successes of service delivery and identify next steps. It also requires frequent and consistent communication with all team members, encouraging any team member to request a meeting at any time to help further the family’s well-being.

**Providers are expected to deliver services in alignment with the NJ KFT Practice Profile and the** [**KFT-Program-Manual.pdf**](https://www.nj.gov/dcf/documents/KFT-Program-Manual.pdf)**.**

9) **The service modalities required for this program initiative are:**

The NJ KFT model is based on the Housing First framework (evidence informed approach that has proven to be effective in ending homelessness for vulnerable populations) and integrates Motivational Interviewing (MI) throughout service delivery. MI is an evidence-based and client-centered framework that promotes behavioral change and assists individuals in addressing and resolving issues related to ambivalence toward change. It employs a conversational method that motivates individuals by guiding them through the five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance.

1. **Evidence Based Practice (EBP) service modalities:** Motivational Interviewing (MI) is integrated within the NJ KFT model.

**b) DCF Program Service Names:** NJ Keeping Families Together

**c) Other/Non-evidence-based practice service modalities:** N/A

10) **The type of treatment sessions required for this program initiative are:**

Complete intake assessment, Individual, Group, Family, Face to Face, One to One, In Family Home, In Community

11) **The frequency of the treatment sessions required for this program initiative are:**

The intensity and frequency of NJ KFT services is responsive to individual family need and circumstances. Families with complex and persistent service needs may need more intense support. At times, NJ KFT programs will have to “dial up” or increase the frequency and depth of family contact. At other times, NJ KFT programs will “dial down” or decrease the frequency of contact, recognizing that family members are making strides on their own.

NJ KFT Services are provided in the family’s home, in community or other related environment as identified by the family.

12) **Providers are required to communicate with Parent/Family/Youth Advisory Councils, or to incorporate the participation of the communities the providers serve in some other manner:** Yes.

13) **The professional development through staff training, supervision, technical assistance meetings, continuing education, professional board participation, and site visits, required for this program initiative are:**

 **NJ KFT Training and Coaching**

NJ KFT staff are required to utilize trainings and coaching to promote competency in the Practice Model. The NJ KFT training curriculum is facilitated by the NJ DCF in collaboration with training partners. The comprehensive curriculum is intended for KFT practitioners, supervisors and other staff implementing NJ KFT. It is designed to strengthen core competencies when delivering the NJ KFT model. Building on best available evidence and home-grown practice experience, this curriculum is intended to provide staff with the tools and skills needed to support their work in delivering NJ KFT to families experiencing homelessness and housing instability with complex service needs.

All new NJ KFT staff are required to complete all courses in the training curriculum; supervisors are required to complete additional supervisory training.

The curriculum is delivered through a mix of self-paced and “live” instructor led modalities and include the following courses:

* NJ KFT Practice Training
* NJ KFT Housing
* NJ KFT and Principles of Motivational Interviewing (MI) and MI Practice Session
* Moving On
	+ Intro to Moving On and Using the Housing Acuity Index
	+ Creating a Moving on Culture
* ***Additional Supervisory Training***
	+ DCF Training for NJ KFT Supervisors
	+ Principles of Motivational Interviewing (MI) for NJ KFT Supervisors
	+ Moving On for NJ KFT Supervisors

Following the initial round of training, staff participate in ongoing practice sessions and learning collaboratives to strengthen and sustain competency in the model.

**NJ KFT Technical Assistance**

In addition to training and coaching, DCF’s Office of Housing provides technical assistance to Providers implementing NJ KFT. This includes the following activities:

* Case Consultation – family specific discussions with DCP&P that include OOH, and other partners (such as the DCA), as needed.
* Provider Operations Team – OOH facilitates team meetings with NJ KFT Providers. These includes individual and peer discussions that focus on emerging trends, program development, contracting and other functions related to program implementation.

**Site Visits**

The NJ KFT initiative is monitored by the DCF Office of Housing (OOH) and Office of Monitoring (OOM). DCF teams’ partner to complete site visits and support program improvements using a CoQI (Collaborative Quality improvement) process.

14) **The court testimony activities, which may address an individual’s compliance with treatment plan(s); attendance at program(s), participation in counseling sessions, required for this program initiative are:** N/A

15**) The student educational program planning required to serve youth in this program:**  N/A

1. **Resources - The below describes the resources required of the contractor to ensure the service delivery area, management, and assessment of this program.**

1) **The program initiative’s physical service site is required to be located in:**

2) **The geographic area the program initiative is required to serve is:**

3) **The program initiative’s required service delivery setting is:**

Family Home, Community

4) **The hours, days of week, and months of year this program initiative is required to operate:**

24 hours per day; 7 days per week; 12 months per year

5) **Additional procedures for on call staff to meet the needs of those served twenty-four (24) hours a day, seven (7) days a week?**

 Yes.

6) **Additional flexible hours, inclusive of non-traditional and weekend hours, to meet the needs of those served?**

 Yes.

7) **The language services (if other than English) this program initiative is required to provide:**

The contractor’s staff will reflect the populations whom they will be serving and will provide services that are respectful of the culture, ethnicity, and language(s) of the families being served.

8) **The transportation this program initiative is required to provide:**

Providers are responsible for providing, or assist families in securing, limited non-emergency transportation with the goal of accessing concrete support services required to meet the family’s immediate needs and mee their service goals.

9) **The staffing requirements for this program initiative, including the number of any required FTEs, ratio of staff to clients, shift requirements, supervision requirements, education, content knowledge, staff credentials, and certifications:**

The primary role of KFT staff is to:

• Establish a trusting relationship with families to promote child well-being and family stability, while improving the capacity of caregivers to provide a safe and permanent home for their children.

• Work with the family to develop an integrated case plan that includes housing needs as well as other services needed by the family.

• Ensure housing retention and improve housing stability among families as a platform for ongoing engagement and family stability.

• Work with families to devise and implement a comprehensive, family-based service plan that focuses on child safety, positive family functioning and wellness.

• Build a network of support within the program and among tenants that focuses on trust, well-being, and social/community integration.

• Advocate on behalf of parents and children to ensure they understand the

requirements of the social services in which they are engaged and facilitate access to public benefits available to them.

• Act as a liaison between parent and service provider(s) when necessary while building the capacity of the caregiver and child to communicate effectively and advocate for themselves.

• Motivate clients to seek licensed substance use disorder treatment and/or participate in recovery supports, as appropriate.

A key factor in the success of this project is the development of a KFT staffing team to support families placed into housing. Ensuring the safety, stability, and well-being of vulnerable children and families is complicated, requiring a wide range of information and practice knowledge. One worker practicing alone with an individual caseload cannot know and do everything that needs to be done. Thus, the contractor shall develop and utilize interdisciplinary teams to work with families. The team is a source for information, understanding, consultation, joint practice, and accountability. Each member of the team should bring a variety of skills, life experiences, and perspectives.

**Core NJ KFT Staffing Roles**

Staffing needs to be reflective of the individuals to be served in the proposed program and should include the following core staffing roles:

* Direct service
	+ NJ KFT Practitioners (Case Manager, Housing Specialists and Employment Specialists, *as applicable*)
	+ NJ KFT Clinicians
* Indirect service
	+ NJ KFT Program Managers (Supervisors, Managers, or Program Directors)

When selecting staff, providers must identify individuals with the credentials and/or competencies to serve families facing a range of co-occurring challenges, including but not limited to substance use disorders, mental health, domestic violence, and trauma histories. Peers may also be built into an agency’s NJ KFT staffing structure. All NJ KFT staff must adopt a “whatever it takes” approach to be seen as a true source of support for the families.

Sample job descriptions, to include credentials, can be found in the NJ [KFT-Program-Manual.pdf](https://www.nj.gov/dcf/documents/KFT-Program-Manual.pdf).

10) **The legislation and regulations relevant to this specific program, including any licensing regulations:**

The contractor must have access to appropriate housing units that meet HUD Housing Quality Standards as set forth in 24 CFR 982.401 and must comply with Housing Choice Voucher rules as set forth in 24 CFR and the DCA Administrative Plan.

1. **The availability for electronic, telephone, or in-person conferencing this program initiative requires:**

OOH facilitates various team meetings with NJ KFT Providers. These includes individual and peer discussions that focus on emerging service trends, program development, contracting and other functions related to program implementation (data management, case consultations etc.)

The Provider conducts and participates in ongoing case conferences with CP&P and other community providers to ensure coordinated planning for the family and an integration of services and resources.

1. **The required partnerships/collaborations with stakeholders that will contribute to the success of this initiative:**

The needs of vulnerable families cannot be met by one public service system. NJ KFT teams must consider the holistic needs of families and collaborate with families themselves, as well as multiple services, professionals, and systems to knit together services that are flexible and responsive.

Providers with established partnerships and experience working collaboratively to serve families are well-positioned to take on the NJ KFT approach.

Stakeholder collaborations must have a shared focus on family success across all partners. As such, planful collaboration is an important activity for NJ KFT teams when working with other stakeholder partners to support families. The following are considerations for working with various stakeholder partners to implement NJ KFT. While not intended to be an exhaustive list, the partnerships highlighted below are considered central to supporting family success.

* Youth and Families
* State Departments and Agencies (Department of Community Affairs (DCA), Department of Labor (DOL) and Other Departments)
* Landlords and Housing Developers
* Community Partners
* DCP&P

For select KFT sites, NJ DCF and PennReach have MOAs, through which PennReach has set aside housing units in Hudson, Passaic and Monmouth Counties that are accessible to CP&P eligible families. DCF’s Contracted Provider is required to enter into its own MOA with PennReach to ensure a mutual understanding of roles and responsibilities regarding the units.

1. **The data collection systems this program initiative requires:**

Data collection systems provided by DCF and is no cost to Provider agencies includes, but isn’t limited to: MS Excel, Survey Monkey, myNewJersey Document Library or other DCF approved data platform. These systems are utilized to support data management, reporting and evaluation processes.

1. **The assessment and evaluation tools this program initiative requires:**

DCF requires the use of standardized assessment and evaluation tools and reserves the right to determine the standard screening and/or assessment tool that will be utilized throughout the intervention.

Providers are required to complete standardized assessment tools, within designated timeframes, explaining to the family what is hoped to be learned from them. It is expected for assessment results to be recorded in nonjudgmental language.

Assessments of family safety, risk and functioning are conducted at intake, throughout the intervention and prior to discharge using standardized tools.

Documentation of assessments will be entered in a DCF approved data platform within prescribed timeframes.

Standardized tools utilized throughout the NJ KFT intervention include, but is not limited to:

* DCF approved safety and risk assessments
* Bio-psychosocial assessments
* Modified Arizona Self-Sufficiency Matrix (ASSM)
* NJ KFT Moving On Acuity Index
* NJ KFT Fidelity Tool
* NJ KFT Baseline Survey and Services Survey
1. **Outcomes - The below describes the evaluations, outcomes, information technology, data collection, and reporting required of the contractor for this program.**

1) **The evaluations required for this program initiative:**

DCF utilizes a structured evaluation and Collaborative Quality Improvement (CoQI) process to identify areas needing improvement, analyze strengths and support program enhancements. NJ KFT Providers are required to participate in the following monitoring, CoQI and evaluation activities.

**Monitoring:** Monitoring activities ensure program effectiveness and includes-but isn’t limited to- aiding in the design or refinement of program-specific monitoring tools, assisting with participant recruitment for client interviews, making available case records and site visits.

**Collaborative Quality Improvement:** CoQI activities utilize qualitative and quantitative data to identify strengths and areas of improvement and develop improvement plans.

**Evaluation:** Evaluation activities occur in collaboration with DCF, external evaluators, and/or consultants and may include the following activities:

* Measure and report on standardized performance and outcome indicators;
* Develop and maintain clear and organized systems of data collection to seamlessly submit reports to DCF;
* Participate in DCF implementation teams;
* Meet with DCF staff and/or external evaluators/consultants at regular intervals to ensure implementation, evaluation and data reporting requirements are met. Regular evaluation and CoQI meetings are held as follows:
	+ Monthly individual and group calls with NJ KFT program managers
	+ Quarterly CoQI calls with NJ KFT program staff and DCF staff
	+ At least 4 annual grantee meetings held in person, by phone, or through webinar. At least two staff from each program shall participate in these meetings.
	+ Bi-annual fidelity observations of NJ KFT practitioners.

Integrated within the above-listed activities, DCF gathers feedback from NJ KFT parents to ensure the experiences of children and families inform and guide programmatic decisions.

2) **The outcomes required of this program:**

1. **Short Term Outcomes**: N/A. NJ KFT Is a long-term supportive housing intervention.
2. **Mid Term Outcomes:**
* Improve housing stability for child welfare involvement families.
* Improve caregiver reported well-being (parenting).
* Improve child reported well-being.
* Improve family stability (i.e., income, employment).
1. **Long Term Outcomes:**
	* Reduce recidivism within the child welfare system.
	* Integration of housing services within the child welfare service system.

3) **Required use of databases:**

The Provider must have the capacity to measure and report on outcome indicators identified by DCF and any other outcomes proposed in their application and develop and maintain clear and organized systems of data collection to seamlessly distribute reports to DCF.

4) **Reporting requirements:**

As part of the data collection process, NJ KFT programs are responsible for completing the following reports as scheduled; in addition to related reporting requested by DCF.

**Enrollment** - Baseline family surveys. The baseline family survey collects information on each family enrolled in NJ KFT including demographic information, risk factors, and family structure. It is completed by providers for each NJ KFT family within 30 days of enrollment in the NJ KFT program.

**Quarterly:** Services Utilization report. In the service report, NJ KFT programs are asked to submit data related to families’ use of services, and success and challenges for the quarter. Instructions for quarterly reporting can be found in Appendix I of the [KFT-Program-Manual.pdf](https://www.nj.gov/dcf/documents/KFT-Program-Manual.pdf). Specific areas of inquiry include:

* + Family Data—this includes service utilization and intermediate outcomes for each family served during the quarter. Intermediate outcomes are measured using the Arizona Self-Sufficiency Matrix. Services data are collected every quarter, but the intermediate outcomes data are submitted twice a year, using the same report.
	+ Narrative Data—NJ KFT programs are asked to submit brief narratives that describe their program’s successes, challenges, and requests for technical assistance.

Analyses of services data is conducted using aggregate data from all NJ KFT Service Providers.

The above program reporting requirements are in addition to mandatory reporting requirements from the DCF Office of Contract Administration; that includes but isn’t limited to quarterly expenditure reports.

1. **Signature Statement of Acceptance:**

By my signature below, I hereby certify that I have read, understand, accept, and will comply with all the terms and conditions of providing services described above as *Required Performance and Staffing Deliverables* and any referenced documents. I understand that the failure to abide by the terms of this statement is a basis for DCF’s termination of my contract to provide these services. I have the necessary authority to execute this agreement between my organization and DCF.

Geographic Area Served:

Name:

Signature:

Title:

Date:

Organization:

Federal ID No.:

Charitable Registration No.:

Unique Entity ID #:

Contact Person:

Title:

Phone:

Email:

Mailing Address:

********