



The Hartford Courant.

A TRIBUNE PUBLISHING COMPANY

Affidavit of Publication

State of Connecticut

Thursday, March 03, 2011

County of Hartford

I, Joy Shroyer, do solemnly swear that I am Financial Operations Assistant of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notice was inserted in the regular edition.

On dates as follows: 03/03/2011	\$35.30
03/01/2011	\$40.30
03/02/2011	\$35.30

For a total of: **\$110.90**

VILLAGE FOR FAMILY & CHILDRE
063950
ZONE 6

PUBLIC NOTICE
The Village for Families & Children, Inc. FILING APPLICATION FOR CERTIFICATE OF NEED-OFFICE OF HEALTH CARE ACCESS. Gale A. Rodriguez, MPH President & CEO, 1680 Albany Avenue, Hartford, CT 06105 is filing an application for a certificate of need with the Office of Health Care Access in the State of Connecticut for a one bed expansion of the existing Eagle House Psychiatric Residential Treatment program in order to increase the capacity to serve clients. There is no associated capital expenditure.

Financial Operations Assistant
Joy Shroyer

Subscribed and sworn to before me on March 3, 2011

Notary Public

WILLIAM B. McDONALD
NOTARY PUBLIC, CONNECTICUT
MY COMMISSION EXPIRES FEB. 28, 2014

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Hartford Courant Public Notice

March 1, 2011 – March 3, 2011 for three full days

The Village for Families & Children, Inc. FILING APPLICATION FOR CERTIFICATE OF NEED-OFFICE OF HEALTH CARE ACCESS, Galo A. Rodriguez, MPH President & CEO, 1680 Albany Avenue, Hartford CT 06105 is filing an application for a certificate of need with the office of health care access in the State of Connecticut for a one bed expansion of the existing Eagle House Psychiatric Residential Treatment program, in order to increase the capacity to serve clients. There is no associated capital expenditure.

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Brian P. Reilly
Chairman of the Board

Galo A. Rodriguez, MPH
President and CEO

AFFIDAVIT

Applicant: The Village for Families and Children, Inc.

Project Title: Eagle House Psychiatric Residential Treatment Facility Expansion

I, Edward Hackett, CFO of The Village for Families and Children being duly sworn, depose and state that The Village for Families and Children's information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.



Edward Hackett

August 29, 2011

Date

Subscribed and sworn to before me on August 29, 2011.



Linda E. Lock
Notary Public

My commission expires: August 31, 2013

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SECRETARY'S CERTIFICATE

I, **Andrea Barton Reeves** being the duly authorized and elected **Secretary of the VILLAGE for Families & Children, Inc.**, hereby certify that the following is a full and true copy of a resolution adopted at a meeting of the **Board of Directors of the VILLAGE for Families & Children, Inc.**, a Connecticut Corporation, held on the 28th day of **June 2011**, at which a quorum was present, it was duly

RESOLVED that the Board of Directors of the VILLAGE for Families & Children, Inc., hereby authorizes **Dr. Galo A. Rodriguez, MPH President and Chief Executive Officer**, to assume guardianship of dependent children and to enter contracts on behalf of the VILLAGE for Families & Children, Inc.

BE IT FURTHER RESOLVED THAT Brian P. Reilly, Chairman of the Board, is duly authorized by the Board of Directors of the VILLAGE for Families & Children, Inc., to enter contracts on behalf of the VILLAGE for Families & Children, Inc.

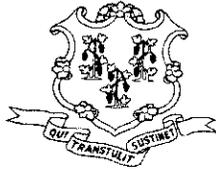
BE IT FURTHER RESOLVED THAT Ed Hackett, Chief Financial Officer, is duly authorized by the Board of Directors of the VILLAGE for Families & Children, Inc., to enter contracts on behalf of the VILLAGE for Families & Children, Inc.

And I so further certify that the above resolution has not been in any way altered, amended or repealed, and is now in full force and effect.

IN WITNESS WHEREOF, I have hereunto set my hand as Secretary and affixed the corporate seal of said The Village for Families & Children, Inc. this 29th day of August 2011.


Andrea Barton Reeves, Esq.
Secretary of the Corporation

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**State of Connecticut
Office of Health Care Access
Certificate of Need Application**

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant: The Village for Families and Children, Inc.

Contact Person: Laurie Valentine

Contact Person's

Title: Director of Compliance and Privacy

Contact Person's

Address: 1680 Albany Avenue, Hartford, CT 06105

Contact Person's

Phone Number: (860) 297-0522

Contact Person's

Fax Number: (860) 233-6454

Contact Person's

Email Address: lvalentine@villageforchildren.org

Project Town: Hartford

Project Name: Eagle House Psychiatric Residential Treatment Facility Expansion

Statute Reference: Section 19a-638, C.G.S.

Estimated Total

Capital Expenditure: \$0

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1. Project Description: Increase in Licensed Bed Capacity

- a. **Please provide a narrative detailing the proposal, which chronicles the history of the service earmarked for an increase in licensed beds and provides a rationale for the proposed licensed bed increase.**

The Eagle House Psychiatric Residential Treatment Facility at the Village for Families and Children, Inc. in Hartford, CT was opened in 2000 in order to serve the needs of children with severe mental health needs. Eagle House is one of the four Psychiatric Residential Treatment Facilities in the state of Connecticut. The program had a census capacity of 13 residents for several years, but in order to meet this census there were times children would have to share rooms which proved to be difficult with children with such an acute psychiatric presentation. In 2010 an opportunity to transition the program to a building with the capacity to serve 14 children in single occupancy rooms was completed. These single occupancy bedrooms will allow the program to increase our ability to provide services to clients who are sexually reactive or who have difficulties with a roommate. The new building is also larger which will allow for additional programming space as well as family visitation areas, which is essential to our family engagement process. As a result of the increase bed capacity, we are requesting that our licensed bed capacity be increased from 13 to 14 in order to serve the growing demand for sub-acute beds in the state. An increase in our population to 14 children will not require any programmatic or service adjustments or require additional staffing as we will continue to meet the ratio of 4 to 1 on both first and second shift and 7 to 1 on third shift.

- b. **Provide in table format the current and proposed number of (1) licensed, (2) staffed and (3) available beds for each unit/location involved in this proposal.**

Criteria	Current Bed Capacity	Proposed Bed Capacity
Licensed	13	14
Staffed	14	14
Available Beds	14	14

- c. **Provide letters that have been received in support of the proposal.**

See Appendix A – Letters of Support

2. Clear Public Need

- a. **Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.**

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There are often many children waiting in inpatient psychiatric hospital facilities for a Psychiatric Residential Treatment Facility (PRTF) bed. Their prolonged stay in such an environment can prove to be detrimental to their mental health as well as costly for the state and their families. As of August 12, 2011, the program was at capacity with 10 active referrals on the waitlist. There are currently 59 PRTF beds in the state of CT and there are times when all these beds are filled and there are children in need of a PRTF bed. In 2010, 73 children exceeded their length of stay in an inpatient psychiatric hospital facility because they were waiting for a PRTF bed. Approving an additional bed in our PRTF program would assist in alleviating this need.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

We currently operate a 13 bed PRTF program at the 1680 Albany Avenue campus of the Village for Families and Children in Hartford, CT. This proposal is requesting that the current facility be licensed for 14 beds instead of 13.

ii. The service area towns and the basis for their selection;

The current PRTF program serves all towns in the state of CT as the need for PRTF beds is a statewide need and we would continue to serve the entire state of CT with the addition of a 14th bed.

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

The PRTF programs serves boys and girls, ages 6 to 12, with severe mental health needs who are transitioning from an acute inpatient psychiatric hospitalization to community placement in a biological relative's home, foster home, or long-term residential program. In 2010 the Eagle House PRTF program at the Village received 109 referrals from inpatient Psychiatric facilities and community based providers. Of those 109 children 28 were provided services by the Eagle House PRTF program.

iv. How and where the proposed patient population is currently being served;

The Eagle House PRTF program currently resides at 1680 Albany Avenue, Hartford, CT 06105 in the Brainard Building on campus. Eagle House is a DCF licensed 13 beds Psychiatric Residential Treatment Facility. The proposed increase of one additional bed would exist within this current facility and all services provided by the PRTF would be extended to this additional bed.

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- v. **All existing providers (name, address, services provided) of the expanded service in the towns listed above and in nearby towns;**

There are three additional PRTF programs in the state of CT who also provides statewide services. They are:

Boys and Girls Village
528 Wheelers Farm Rd
Milford, CT 06461

The Children's Center of Hamden
1400 Whitney Avenue
Hamden, CT 06517

Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052

- vi. **Describe existing referral patterns in the area to be served by the proposal; and**

The current referral process for PRTF programs is that any provider interested in referring a client to a PRTF must go on line complete the PRTF referral document, obtain authorization from the insurance carrier, then fax the referral document to each PRTF program for consideration. Children are accepted to each program based on bed availability and the programs ability to meet the needs of the client being referred.

- vii. **The effect of the proposal on existing providers, explaining how current referral patterns will be affected by the proposal.**

The current referral process will not be disrupted by an additional bed being added to our current license.

- c. **Provide the following regarding the proposed increase in licensed beds:**

- i. **Explain the specific rationale for the increase in beds at each unit/location, including:**

- (1) **The calculation or other methods by which the proposed increases were determined, clearly identifying all underlying assumptions used;**

The current PRTF program on campus now has the capacity to serve 14 children but we are only licensed to serve 13 so we are asking for our bed

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capacity to be increased so that we can utilize that additional bed as needed.

(2) The patient population that will be served; and

The Eagle House PRTF program serves boys and girls, ages 6 to 12, with severe mental health needs who are transitioning from an acute inpatient psychiatric hospitalization to community placement in a biological relative's home, foster home, or long-term residential program.

(3) The benefits of each proposed increase.

Offering an additional PRTF bed would assist in reducing the number of clients who often time are waiting in inpatient psychiatric hospital settings both in state and out of state for a PRTF bed.

ii. For the last three complete FYs, the current FY-to-date, and the first three full years of the proposal, provide the following (by service as relevant to the proposal):

- (1) Occupancy rate;**
- (2) Average daily census;**
- (3) Variability in census including peak census; and**
- (4) Patient days.**

Eagle House

	FY09	FY10	FY11	FY12* YTD 8/12/11
Occupancy Rate*	82.47%	91.99%	96.56%	102%
Average Daily Census	10.72	11.96	12.55	13.21
Lowest Census (Month)	6.5 (Sep 08)	11.4 (Sep 09)	11.1 (Jul 10)	July 12.94
Highest Census (Month)	12.8 (Feb & Apr 09)	12.6 (Nov 09)	13.7 (Jan 11)	August 13.92
Patient Days	3913	4365	4582	568
Volume	29 (3 children w/ 2 episodes) 32 episodes	37 (1 child w/ 2 episodes) 38 episodes	49 (1 child w/ 2 episodes) 50 episodes	16

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**Eagle House
Projected Data**

	FY13	FY14	FY15
Occupancy Rate*	95.8%	95.8%	95.8%
Average Daily Census	13	13	13
Lowest Census (Month)	9.7	9.7	9.7
Highest Census (Month)	12.9	12.9	12.9
Patient Days	4680	4680	4680

- d. **Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.**

See Appendix B Ziegler, Ph.D., David (n.d.). Appropriate and Effective Use of Psychiatric Residential Treatment Services. Retrieved on August 17, 2011 from http://www.jaspermountain.org/appropriate_effective_prts.pdf.

This article supports the idea that psychiatric residential treatment is an essential part of the mental health continuum and that children with intensive treatment needs should be afforded access to this level of care in a timely manner. The addition of one bed in our PRTF program will enable us to provide access to this level of care to a larger number of children each year.

See Appendix C “Characteristics of Residential Treatment for Children and Youth with Serious Emotional Disturbances” by Abt Associates, Summer, 2008

This report clearly indicates that residential treatment is needed for some children with complex needs and that delayed access to this treatment can have serious negative consequences, such as clinical deterioration, educational delays, increased involvement with the social and juvenile justice systems, and irreparable harm to the youth and those around them. By increasing the access to this level of care for more children, we will be able to help them avoid additional challenges to their mental health and well-being.

- e. **Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.**

An increase of our license bed capacity from 13 to 14 beds will not lead to a duplication of services as we are currently providing such a service.

3. Actual & Projected Volume

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- a. For each service involved in this proposal, provide volumes for the most recently completed fiscal year ("FY") by town.

FY 7/1/10 -6/30/11				
Town of Residence	Enrolled as of 7/1/10	7/1/10 - 6/30/11	Total	
Bloomfield		2	2	4.1%
Bridgeport		2	2	4.1%
East Haven	1	1	2	4.1%
Ellington		1	1	2.0%
Hartford *	6	9	15	30.6%
Manchester		2	2	4.1%
Mansfield		1	1	2.0%
Middletown	2		2	4.1%
New Britain		2	2	4.1%
New Haven		2	2	4.1%
New London		1	1	2.0%
North Branford**	1	0	1	2.0%
Norwich		3	3	6.1%
Southington		2	2	4.1%
Stafford Springs		1	1	2.0%
Uncasville		1	1	2.0%
Wallingford		1	1	2.0%
Waterbury	1	1	2	4.1%
West Hartford		1	1	2.0%
West Haven		3	3	6.1%
Willimantic		2	2	4.1%
Total	11	38	49	100.0%
* Client "Rate Adjustment" not included				
** Client d/c then re-enrolled in F/Y 11 - only counted once here				

- b. Complete the following table for the past three FYs and current fiscal year ("CFY"), for each service involved in this proposal.

Table 1: Actual Service Volumes

	Volume*			
	FY 09	FY 10	FY 11	CFY 12
Eagle House PRTF Admissions	29	37	39	4 admits

Total	29	37	39	4
FY runs from July 1 – June 30th				

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

** Identify each service type and location and add lines as necessary. Provide number of visits and/or number of admissions for each service listed, as appropriate.

*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the table above.

The increase in volume represented in the table is a reflection of the reduction in our length of stay over the past several years. The current length of stay for all PRTFs in CT is 4 months, based on a shorten length of stay we have been able to serve more children each year.

- d. Complete the following table for the first three full fiscal years (“FY”) of the proposed service increase (if the first year is a partial year, include that as well).

Table 2: Projected Service Volumes

	Projected Volume (First 3 Full Operational FYs)**			
	FY 12	FY 13	FY 14	FY 15
Eagle House PRTF	40	43	43	43
Total	40	43	43	43
FY is July 1 – June 30th				

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.

*** Identify each service type and location and add lines as necessary. Provide number of visits and/or number of admissions for each service listed, as appropriate.

**** Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g. July 1-June 30, calendar year, etc.).

- e. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

With the addition of one bed to our current PRTF and with a current length of stay of 4 months, we would be able to at minimum serve 3 additional clients per year based on discharges from the program and referrals.

4. Quality Measures

- a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

See Appendix D – Resumes

- b. Explain how the proposal contributes to the quality of health care delivery in the region.

The Eagle House PRTF program currently provides quality health care services for children with severe mental health needs in the state of CT. This proposal is requesting that we offer an addition bed to our current service capacity in order to meet the need of additional children and families each year.

- c. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines

The following standards are being utilized in relation to this proposal: The Village Eagle House PRTF currently meets all of these guidelines.

Council On Accreditation Standards for Residential Treatment

COA is an international, independent, not-for-profit, child- and family-service and behavioral healthcare accrediting organization. COA views accreditation as a catalyst for change that builds on an organization's strengths and helps it achieve better results in all areas. The accreditation process is designed to meet the needs of diverse organizations. An organization is evaluated against best-practice standards, which are developed using a consensus model with input from a wide range of service providers, funders, experts, policymakers and consumers.

COA accreditation is extensive and focuses on areas related to: Administration and Management (Ethics, Finance, Governance, Human Resources, Performance and Quality Improvement, Risk Prevention and Management); Service Delivery Administration (Administrative and Service Environment, Behavior Support and Management, Client Rights and Training and Supervision); and Program-Specific standards for Services. The Village for Families & Children submits an annual monitoring report to COA and undergoes a full reaccreditation every four years.

Village Eagle House Residential Treatment Services are accredited through COA, and provide a time limited, interdisciplinary, psycho-educational, and therapeutic 24-hour-a-day structured program with community linkages, provided through non-coercive, coordinated, individualized care, specialized services and interventions. Residential Treatment Centers provide highly customized care and services to individuals following either a community based placement or more intensive intervention, with the aim of moving individuals toward a stable, less intensive level of care or independence.

Department of Children and Families (DCF) Licensing

Eagle House is licensed by the Department of Children and Families (DCF) as a Child Care Facility to provide Residential Treatment Services for male and female youth. DCF conducts quarterly field inspections and relicenses Eagle House every two years.

DCF Licensing monitors compliance with administrative areas related to:

1. Policies and operating procedures for administrative services: education; mandated child abuse and neglect reporting responsibilities; personnel, including utilization of volunteers and interns, training and staff development;
2. Human Resources screening and credentialing practices;
3. Client rights and ensuring that services address the cultural, racial, ethnic and language needs of the residents and the protection of cultural, ethnic and sexual minorities;
4. Maintenance of the physical plant of the facility;
5. Quality assurance activities;

6. HIPAA practices to safeguard client confidentiality;
7. Staffing requirements for client/staff ratios and credentialing;
8. Safety management;
9. Financial practices and viability;
10. Board leadership.

Residential Services are observed and clients and staff are interviewed as part of the license monitoring process. DCF's extensive review focuses on service areas related to:

1. entry and orientation;
1. routine and emergency referral and admissions process;
2. Clinical Services: family involvement; clinical services, including clinical staff ratios; treatment or service planning; and discharge planning;
3. visitation;
4. recreational activities;
5. off campus activity including transportation, travel and supervision, and involvement with the local community;
6. work opportunities;
7. protection of resident's money and personal belongings;
8. resident clothing; storage and replacement;
9. laundry;
10. dietary services;
11. daily routine;
12. behavior management including the use of physical restraint and seclusion;
13. psychiatric emergencies including but not limited to suicidal ideation, gesturing or other behavior, which may present a risk of harm to self or others; and
14. Medical Services: well child care services; medical emergencies; administration of medications.

Department of Social Services (State of CT Medicaid Agency)

In order to enroll in Medicaid and receive payment from the department, The Village Eagle House Psychiatric Residential Treatment Facility (PRTF) is required to:

1. Meet and maintain all applicable licensing, accreditation and certification requirements;
2. Meet and maintain all DSS Medicaid enrollment requirements; and
3. Have a valid provider agreement on file specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.
4. Satisfy all federal and state requirements governing the use of restraint and seclusion including, but not limited to, a written attestation of facility compliance with CMS standards governing the use of restraint and seclusion and filed annually with DSS.

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DSS provides reimbursement for Eagle House services that are provided to Medicaid eligible persons under the age of 21 years. As a condition for participation as a PRTF, Eagle House services include:

1. Therapeutic services provided by PRTF staff;
2. Active treatment services including, but not limited to, individual, group and family therapy;
3. Diagnostic testing and assessment;
4. Room and board; and
5. Case management, discharge planning.

All Eagle House admissions must have a Certification of Need based on a determination that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the client;
2. Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.

The Village Eagle House PRTF currently meets all of these guidelines.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

The Village for Families and Children is a non-profit corporation.

b. Does the Applicant have non-profit status?

Yes No

See Appendix E - tax letter confirming non-profit status

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant.

See Attachment F - DCF/DPH Licenses

d. Financial Statements

- i. **If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.**

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- ii. **If the Applicant is not a Connecticut hospital (other health care facilities):**
Audited financial statements for the most recently completed fiscal year.
If audited financial statements do not exist, in lieu of audited financial
statements, provide other financial documentation (e.g. unaudited
balance sheet, statement of operations, tax return, or other set of books.)

See attachment G - 2010 Audit

- e. **Submit a final version of all capital expenditures/costs as follows:**

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	\$0
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	\$0
Medical Equipment Lease (Fair Market Value) ***	\$0
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	\$0
Total Project Cost (TCE + TCC)	\$0
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	\$0

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

- f. **List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.**

There is no additional cost to the organization for an increase of one licensed bed for our current PRTF program. Direct service cost will be covered by Medicaid.

- g. **Demonstrate how this proposal will affect the financial strength of the state's health care system.**

This proposal can assist in the reduction of the cost to maintain a client unnecessarily in an inpatient psychiatric hospital setting, which will result in savings for the state's health care system.

6. Patient Population Mix: Current and Projected

- a. **Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed service increase.**

Table 3: Patient Population Mix

	Current** FY 12	Year 1 FY 13	Year 2 FY 14	Year 3 FY 15
Medicare*				
Medicaid*	13	43	43	43
CHAMPUS & TriCare				
Total Government	13	43	43	43
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government	0	0	0	0
Total Payer Mix	13	43	43	43

* Includes managed care activity.

** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

- b. **Provide the basis for/assumptions used to project the patient population mix.**

Based on our current patient population mix related to reimbursement for services, we are predicting that Medicaid will be the primary coverage for children we serve in the future.

7. Financial Attachments I & II

- a. **Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. Complete Financial Attachment I. (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.**

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The project increases the capacity of a sub-acute program from 13 beds to 14 beds. Although the increase in capacity provides the opportunity to serve one additional child, it is unlikely that the program will run at maximum capacity on an ongoing basis. Factors influencing whether the program runs at full capacity are the length of stay of its clients along with the timing and availability of new clients. Based on current trends, we estimate that the program will run at capacity for 4 to 6 months each year

- b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Complete Financial Attachment II. The projections must include the first three full fiscal years of the project.**

As indicated in the population mix exhibit, the program serves clients that are eligible for Medicaid benefits administered by the Connecticut Behavioral Health Partnership. The increase in capacity will serve additional Medicaid clients.

Based on the assumption that the program will utilize the additional bed for an average of 5 months per year, this will result in additional Medicaid revenue of \$47,989.50 per year. This is calculated as follows 5 months x 30 days/month = 150 days x \$319.93 per day = \$47,989.50.

Additional expenses are limited to variable program costs of food and other incidentals of approximately \$20.17 per day. This will result in incremental expenses of \$3,025.50 (= 150 days x \$20.17 per day).

Incremental impact	Year 1	Year 2	Year 3
Revenue	\$47,990	\$47,990	\$47,990
Expense	\$3,026	\$3,026	\$3,026

- c. Provide the assumptions utilized in developing both Financial Attachments I and II (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).**

Revenue will be at the per diem rate (\$319.93) currently authorized by the Connecticut Behavioral Health Partnership.

Utilization is based on the additional bed being used an average of 5 months throughout each year.

Expenses are based on historical averages for the program.

- d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s) earmarked for licensed bed increase.**

New rates are not being proposed as part of the project.

- e. **Explain any projected incremental losses from operations contained in the financial projections that result from the implementation of the proposed licensed bed increase.**

Losses are not anticipated with the implementation.

- f. **Describe how this proposal is cost effective.**

The proposal improves the cost of serving each client because it can serve 14 children with the same staffing required to serve its current capacity of 13 children.

There is no additional cost to the program to increase our licensed bed capacity from 13 to 14 beds.

APPENDIX A
Letters of Support



KLINGBERG
FAMILY CENTERS

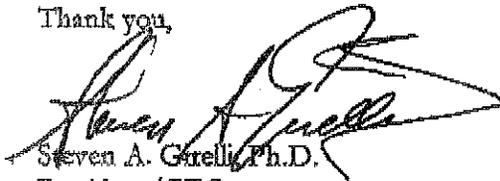
March 24, 2011

Department of Public Health
Office of Health Care Access
410 Capital Ave, MS#13HSA, PO Box 340308
Hartford CT 06134-0308

To Whom It May Concern,

I am writing this letter of support on behalf of the Village for Families and Children's Eagle House Psychiatric Residential Treatment Center's Certificate of Need Application. Eagle House, located in Hartford, is seeking to increase its capacity from 13 to 14 children. This program has been serving children ages 6 to 12 stepping down from psychiatric inpatient units for over ten years with positive outcomes. We recognize the valuable role that community PRTF beds play both in helping prevent children from remaining on inpatient units longer than clinically necessary and in providing support for children in crisis as an alternative to inpatient hospitalization. We are in support of Eagle House's application to increase its bed capacity by one bed and would be happy to answer any questions you may have.

Thank you,


Steven A. Grelli, Ph.D.
President/CEO



Klingberg Family Centers is a private nonprofit treatment agency that has served children, adolescents and their families since 1903.

Accredited with
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FAX COVER SHEET

TO: --- Liz Bryden

ORGANIZATION: Village for Families *Children

FAX #: 860-233-6454

FROM: Megan Albanese / Pat Wilcox

DATE: 3/24/11

TOTAL NUMBER OF PAGES: (including cover)

COMMENTS:

Letter from Pat Wilcox.

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April 1, 2011

Lynn Mangini, MD
 Child & Adolescent Psychiatrist
 Hartford Hospital/Institute of Living
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 Hartford, CT 06106
 (860) 545-7200

The Department of Public Health
 Office of Health Care Access
 410 Capital Ave, MS#13HSA, PO Box 340308
 Hartford CT 06134-0308

To Whom It May Concern,

This is a letter of support for the Certificate of Need of the Village for Families & Children's Eagle House Psychiatric Residential Treatment Center, for the purpose of expanding the capacity of Eagle House from 13 to 14 beds.

Such community Psychiatric Residential Treatment Facilities as Eagle House provide a critical service in the spectrum of community-based resources that offer intensive therapeutic support for children in crisis. Eagle House accepts children 6 to 12 years old who are stepping down from an inpatient level of psychiatric care. The crucial benefit of Eagle House is to decrease the problematic discharge delay from psychiatric hospitals of such children who have concluded successful inpatient treatment, thereby facilitating their return to the community. The addition of one more bed is a welcome enhancement of this valuable resource. It has my strong support.

Sincerely,

A handwritten signature in cursive script that reads 'Lynn Mangini MD'.

Lynn Mangini, MD
 Attending, Child & Adolescent Psychiatrist
 Hartford Hospital/Institute of Living
 Connecticut Children's Medical Center
 Pager 860-825-7326

000025



Emergency Department Fax Cover Sheet

DATE: 4/4/11

TO: LIZ BRYDEN

FAX #: 860-233-6454

FROM: Connecticut Children's Medical Center - Emergency Department (EDOU)
Fax #: (860) 545-9007 / Phone #: (860) 545-9150

Number of pages, including this cover sheet, is 2. If this fax arrives incomplete please call (860) 545-9150.

LYNN pager 860-825-7326

Good luck!

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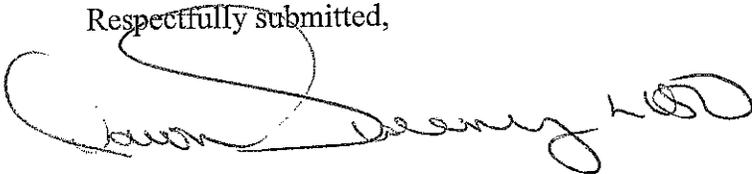
March 23, 2011

To Whom It May Concern:

This letter is in recommendation that The Village for Children and Families in Hartford, Eagle House sub acute be able to add one more space to its current population. My name is Dawn Sweeney and I work for Yale New Haven Child Psychiatric services. The need for single rooms has increased due to our current population that we service. I frequently utilize The Eagle House for traumatized children, who often need single rooms. As has been statistically noted, there were 73 children on discharge delay that directly affects our care for children. If we can not move the more stabilized child we can not accept the other child who may need our acute care and this leads to back ups in our emergency room and inpatient pediatric units.

Eagle House provides quality care for fragile children going through complex mental health issue. I highly respect the program and the staff that provide direct care to the children. I believe that by allowing them one more bed space of availability, you can as well support the quality care for one more child that needs their service.

Respectfully submitted,



Dawn M. Sweeney, LCSW

000327

APPENDIX B
Ziegler, Ph.D., David
(n.d.) Article



**Appropriate and Effective Use of
Psychiatric Residential Treatment Services**
By Dave Ziegler, Ph.D.

Executive Summary

Stakeholders in a comprehensive system of care view psychiatric residential treatment as a dynamic and critical component interfacing with an effective overall mental health system for children (Butler & McPherson, 2006). To be most effective PRTS must be targeted, responsive, and individualized to the needs of the child and the family and have the following characteristics:

- Integrated into the overall system of care and includes a continuum of step-up and step-down services within the same provider organization.
- Offers a comprehensive and ecological model of multi-model treatment interventions into an integrated whole, designed to meet the individual needs of a child and the child's family.
- Commitment to national standards of excellence, a continuous commitment to quality improvement, and have an identifiable treatment philosophy and approach based upon research and empirical evidence.
- Emphasizes the environment around the child that will necessitate family interventions, partnering with families during and after residential services to best meet the child's needs.
- Makes an impact on the child's positive thoughts and perceptions, emotional self-regulation, and pro-social skills and behaviors.

Psychiatric residential treatment services can play several effective roles within the overall system including: a. intensive treatment while maintaining safety, b. a component of a step up/step down plan for a child, c. Treatment of serious disorders that require coordinated multimodal interventions, d. assessing medication level while providing a stabilizing environment, e. alternative to psychiatric hospitalization, and f. a treatment of last resort for children for whom other interventions have been ineffective.

Less appropriate uses of PRTS include: a holding place for a child waiting for a community placement, destabilizing the child by rapidly altering medications or delving into deeper psychological states without sufficient time to re-stabilize, and when the length of time in PRTS is predetermined before admission due to cost, utilization, or other factors unrelated to the needs of the child.

The commonly repeated criticisms concerning the lack of research support for the effectiveness of PRTS lack validity. The comprehensive nature of a multimodal integrated environment presents unusual challenges for isolating variables for causal research. However, considerable research exists to support the overall effectiveness and efficacy of PRTS.

When efforts are made to insure that the proper children are admitted to well designed PRTS, the child, the family, and the system of care can expect individualized, client-centered care that can result in positive outcomes for everyone.

Introduction--Efficacy and Effectiveness of PRTS

A common goal among all stakeholders in the system of care for children is to develop a comprehensive array of services that is sensitive to the needs of children and their families and provides needed care on a continuum of intensity based upon individualized needs. For over fifty years there has been a debate concerning putting children in out-of-home placements. The debate has continued whether it is the orphan asylum of the past or the psychiatric residential treatment center of the present. For a variety of reasons, some well deserved, residential care has been plagued by negative stereotypes and pessimistic sentiments (Frensch & Cameron, 2002). A persistent notion that institutional life is contrary to a child's nature (Whittaker, 2004) has led to "an archaic and inaccurate perception of residential treatment as a single type of ineffective, institutional congregate care for children" (Butler & McPherson, 2006). However, the long standing debate over residential settings has gradually given way to an acknowledgement that the best system of care includes alternatives for the needs of all children regardless of the level of required intensity (Leichtman, 2006; Butler & McPherson, 2006; Lieberman, 2004). Therefore the question has changed from whether residential treatment should be used, to what is the appropriate and effective use of residential treatment in the new system of care.

There is considerable literature and research support for the value of residential treatment of a broad variety of types and approaches, particularly for the sophisticated treatment settings that have met the highest national standards of excellence (CWLA, 2004; Lewis, 2004; Friman, 2000; Handweck, Field & Friman, 2001; Larzelere, Daly, Davis, Chmelka & Handwerk, 2004; Lipsey & Wilson, 1998; Lyman & Wilson, 1992; Pfeifer & Strelecki, 1990; U.S. Department of Health and Human Services, 1999). "Residential services are an important and integral component within the multiple systems of care and the continuum of services" (CWLA, 2005). This statement from the largest children's advocacy organization in the country outlines the new thinking coming from policy makers, system managers, advocates, families, and providers. The many arguments against the use of residential care of the past, including the comparison of one level of care over another, are out of favor due to improper comparisons and lumping divergent services (Handwerk, 2002; Butler & McPherson, 2006). In its place is a more inclusive and practical position that there will always be a number of youth who require the intensive structure and safety of the residential setting. Whether it is the Child Welfare League of America, the Building Bridges initiative, or the providers themselves (AACRC and others), there is wide support from stakeholders that residential care is an essential and important part of the overall system of care past, present and into the future.

The psychiatric residential treatment program of today is not the same as programs of the past, including the very recent past. This fact makes most comparisons to current care and the residential treatment of the past questionable in their validity. The quality Psychiatric Residential Treatment program of today is not only integrated into the overall system of care, but includes a continuum of step-up and step-down services within the same provider organization. Such an internal system of care allows for children and families to change levels of treatment intensity without changing key staff such as psychiatrists, therapists, teachers, and mentors. For child with significant mental health needs, the level of treatment intensity will necessarily change over time if the plan of care is effective.

What Constitutes Good Psychiatric Residential Treatment Services

A quality residential program offers a comprehensive and ecological model (Stroul & Friedman, 1996; Wells, Wyatt & Hobfoll, 1991; Hooper, Murphy, Devaney & Hultman, 2000) of multi-model treatment interventions woven into an integrated whole, designed to meet the individual needs of a child and the child's family. The best programs start with a commitment to national standards of excellence, a continuous commitment to quality improvement, and have an identifiable treatment philosophy and approach based upon research and empirical evidence. Effective programs will emphasize the environment around the child that will necessitate family interventions, partnering with families to best meet the child's needs, and at times may include efforts to identify a family for children without one. Good residential programs know the target populations that they are most effective with and have evidence based approaches for these populations. Good programs make positive impacts on the child's positive thoughts and perceptions, emotional self-regulation, and pro-social skills and behaviors. The best residential programs are integrated into a community of stakeholders who have input into a continual unfolding of quality interventions in an overall environment of safety, respect and effectiveness.

The Best Use of Residential Treatment

For too long residential treatment has been relegated primarily to the placement of last resort. In some situations it may be the case that a child has been unresponsive to treatment that is less intense or insufficiently environmentally integrated, thus necessitating the strengths of a residential setting. The use of residential care as a "last resort" is still a possible role but there can be other roles as well:

Intensive treatment while maintaining safety—Some children cannot be effectively and safely treated in a family setting. Examples of this are serious violent behavior, firesetting, and significant sexual behavior.

One component of an overall treatment continuum—At times the needs of a child may warrant treatment in a variety of settings from maximal to minimal levels of intensity as treatment progresses. Residential care can be an important part of the plan including a back up to serious deterioration in levels of care in community settings.

Treatment of serious disorders that require multimodal intervention—Children with the highest acuity of psychiatric needs often require a complex array of integrated services in a single setting. An example of this are complex trauma disorders where up to a dozen specialized intervention strategies may be needed (Connor, Miller, Cunningham & Melloni, 2002).

Safely assessing psychopharmacological intervention—A child may have serious emotional or behavioral destabilization when medications are significantly altered. For children with several medications, it may be important to insure safety for the child and all concerned while the medication assessment process takes place.

Alternative to hospitalization—A well designed psychiatric residential program can be an effective alternative to hospitalization for many serious children. This can provide advantages

including: keeping the child and family in the community, intensive care in a less restrictive setting, and a significant reduction in cost allowing a length of stay appropriate for the child.

There are also ways that residential treatment should not be used. It should not be a default setting for a child who has completed treatment but is waiting for a placement. A residential setting should not be allowed to destabilize a child's mental health, such as changing medications or opening painful psychological issues without sufficient time to follow through with the ramifications. While there are children who have been shown in research to improve with short stays of six months or less in residential care (Blackman, Eustace, Chowdhury, 1991; Leichtman, Leichtman, Barker & Neese, 2001; Shapiro, Welker & Pierce, 1999), this is based upon a short-term approach of lowering the expectations of treatment through modest and selective goals such as primarily addressing the issue that caused the removal of the child from the family home (Leichtman & Leichtman, 1996). However there is still a place for longer term treatment with specific childhood disorders that are not responsive to short-term interventions (Zegers, Schuengel, van IJzendoorn & Janssens, 2006; McNeal, Handwerk, Field, Roberts, Soper, Huefner & Ringle, 2006; Greenbaum, Dedrick, Friedman, Kutash, Brown, Lardieri & Pugh, 1996). Residential treatment is improperly used when the length of intensive residential treatment is predetermined before admission due to cost, utilization or other factor unrelated to the needs of the child.

Efficacy and Effectiveness of Residential Treatment

It is commonly stated that residential treatment has been shown not to be effective. A closer look at efficacy and effectiveness tells a different story. While there have been weaknesses among the providers of residential care over the years, there have also been very effective services delivered in a residential setting. This point raises an important distinction between an intervention and a setting. Too often this distinction is misunderstood resulting in 'apples and oranges' comparisons (Butler & McPherson, 2006). For example, an evidenced based intervention can be effective in a variety of settings, or the wrong evidence based intervention in a specific setting can be highly ineffective. When discussing whether a placement is the best choice, both the setting and the interventions to be used are both important considerations.

Science is informing the mental health world at an unprecedented pace. Objective research is increasingly being considered to inform decision makers, parents and providers as to what to do more of, and what to discontinue. Science considers all aspects of a situation to form an opinion, not just factors that confirm previous biases. Because there has been a fifty year debate over putting children in residential setting, both sides have presented data to enhance their argument, for or against. We must now move beyond previous biases and look toward objective science.

Whether a treatment setting works depends upon both efficacy and effectiveness. Objectively speaking there is research to support strong efficacy in residential care. At the same time there are consistent questions as to the effectiveness reflected in research on residential treatment (Hair, 2005). This apparent contradiction points to the difficulty in evaluating whether a complex setting works or not. The answer often depends upon the way the question is framed, as well as how outcomes are measured.

There has been decades of research evidence of efficacious treatment of children and adolescents in all settings. When children who receive a broad variety of treatments are compared with control groups of children receiving no treatment, the treatment group is consistently superior with an effective size from .7 to .8 (Casey & Berman, 1985; Baer & Nietzel, 1991; Burns, Hoagwood & Mrazek, 1999; Grossman & Hughes, 1992; Hazelrigg, Cooper & Borduin, 1987; Kazdin, Siegel & Bass, 1990; Shadish, Montgomery, Wilson, Wilson, Bright & Okwumabua, 1993; Weisz, 1987; Weisz, Weisz, Han, Granger & Morton, 1995). Some treatments and some settings have shown better results than others, but treatment efficacy research provides strong and consistent evidence that providing psychological treatment to child clients is much better than not doing so.

Much has been made of the scarcity of causal research on residential treatment. The reason that effectiveness research on residential settings has been either mixed or lacking is primarily due to the complex weave of multiple treatments in an ecological setting. Such an enriched setting of multi-modal treatment variables is not conducive to empirical causal research. Moreover, "the very characteristics that are likely to make (treatment) effective make them more difficult to describe and evaluate...numerous elements of family and agency life weave together with the therapeutic intervention and potentially decrease the chance of finding a positive treatment effect when there is one" (Hair, 2005). Butler and McPherson point out that this lack of empirical evidence in part is based upon the challenge of measuring what residential care does best. They report gains such as: enhanced safety, truancy reductions, consistent medication management, reduced hospitalizations, consistency, structure, caring and nurturing, limit setting, psychosocial support, self-esteem role modeling, time to self-reflect, and focus on mental health issues, all of which are invaluable to the child but are complicated to objectify and analyze. "Thus the literature does not actually reveal much helpful information" (Butler & McPherson, 2006).

Some of the research showing marginal or no positive efficacy makes the conceptual error of comparing some new type of treatment intervention with the traditional treatment setting of residential care. There are studies that indicate poor outcomes with residential care (Burns et.al., 1999; Greenbaum et.al., 1996; Friman, 2000; Ruhle, 2005). Some of these studies again address a setting, not specific treatment interventions. Research on essentially all settings can find poor outcomes (families, hospitals, foster care, schools, etc.). For example, while there is considerable evidence of effectiveness for some uses of family based treatment foster care, other uses have been found to be contraindicated (Farmer, Wagner, Burns & Richards, 2003), or less effective for some populations than residential care (Drais-Parrillo, 2005). Treatment settings in themselves do not insure effectiveness, this can only be done by quality interventions within a treatment setting.

When treatment interventions are the subject of research residential settings the results often show strong improvement (Landsman, Groza, Tyler & Malone, 2001; Hooper et. al., 2000; Weiner & Kupermintz, 2001; Burns et.al., 1999). Research has shown long-term maintenance of gains in clinical functioning, academic skills and peer relationships (Blackman, Eustace & Chowdhury, 1991; Joshi & Rosenberg, 1997; Wells, 1991).

Two predictors of long-term positive outcomes deserve to be specifically mentioned. The quality of the therapeutic relationship in therapy has been found to be one of the most important

predictors of long-term success (Pfeifer & Strzelecki, 1990; Scholte & Van der Ploeg, 2000). In a recent study on attachment representations, children in residential treatment improved in their forming secure attachments and decreasing their avoidance and hostile behavior. However this finding was true only for children with longer stays in residential treatment. The study reported, "When the duration of treatment is extended, the personal attachment backgrounds of clients and treatment staff increase in importance (Zegers, Schuengel, van IJzendoorn & Janssens, 2006). The other long-term predictor of success is positive outlook, life satisfaction and hopefulness. In a 2006 study children in residential treatment increased their hopeful thinking and general well-being, while decreasing psychopathology (McNeal, Handwerk, Field, Roberts, Soper, Huefner & Ringle, 2006). Attitudinal and cognitive variables such as hope have been found to predict outcomes above and beyond psychopathology (Hagen, Myers & MacKintosh, 2005). This study on hope found the children with the highest levels of psychopathology made the most gains after 6 months of residential care.

Therefore a quick statement on the general findings of research indicate: strong support for providing treatment services to child over no treatment, mixed results when evaluating the setting, and strong support for effectiveness with specific treatments in residential settings. It can therefore be said that, in general, treatment provided to the child will be better than none at all, and it is the treatment interventions used in the residential setting that are the determining factor of efficacy and not the setting itself.

The Right Target Population for Psychiatric Residential Treatment

Intensive treatment services in a residential setting are restrictive and potent and should only be a part of the plan of care for a child if needed. There is common agreement that care should be taken before placing a child out of a family setting and particularly when placing the child in a PRTS program. It is important that guidelines exist concerning the right target population while not being so prescriptive that children 'fall through the cracks.' To avoid legislating children out of a needed service, it is essential that the individual child's needs must come first, and the child matched to the proper level of care intensity. The overall criteria for such a restrictive setting is to include only those children who cannot receive the treatment they need while remaining in a family setting.

The historical criteria for admission to PRTS have been:

1. Other treatment resources available in the community do not meet the treatment needs of the child.
2. Proper treatment of the child's psychiatric condition requires services in a psychiatric residential treatment setting under the direction of the psychiatrist.
3. The services can be reasonably expected to improve the child's condition or prevent further regression so that psychiatric residential services may no longer be needed
4. The child has a principal diagnosis of Axis I of a completed 5-Axis DSM diagnosis that is not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism.

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These criteria have provided guidelines while allowing for individual needs to be considered. If proper treatment resources exist in the community, if the child does not need psychiatric oversight, if the treatment can help or prevent further deterioration and if they child has a mental health diagnosis, then the child can be considered. As the system focuses on improving community resources, more children would be screened out due to the first criteria.

The one screening tool that has been used in the past is the Childhood Acuity of Psychiatric Illness. It has been used to inform the admission and discharge decisions but has not been the sole criteria. Like the CASII, where it is possible to have an overall low acuity score yet be appropriate for intensive treatment due to high risk behavior, the CAPI scores do not address all areas of need or interest when making admission decisions. Therefore it cannot be used solely as an indication of proper or improper placement decisions.

There is general agreement that treatment should be individualized, strength-based, and integrated. Therefore it is important to insure that admission and discharge decisions are individualized and not based upon a score or single or multiple indicators not related to the needs of the child.

It is important that the child have a serious mental health issue to be appropriate for PRTS. However, the treatment needs of the child should be the primary consideration and not the diagnostic category, which often varies by practitioner. Frequently a child's diagnosis changes when the provider changes. Diagnostic categories are not discreet in many cases and children needing PRTS care typically have multiple Axis I diagnoses. The diagnosis of a child at admission has been found to be a negligible factor in success at discharge (Hair, 2005), thus the specific diagnosis should not be used as a factor to screen a child in or out of PRTS. For example, if a child is dangerous due to a mental health diagnosis, the child should not be screened out due to which diagnosis the child has been given. Using another example, if a child is suicidal and has a serious oppositional defiant diagnosis, the child should receive the treatment needed in a safe setting, which could necessitate a PRTS level of care, regardless of the diagnosis.

Research consistently indicates that children with supportive families do better in general, do better in school, do better in treatment, and do better coming out of PRTS. This makes logical sense. However, true trauma informed care necessitates that a child who is unlucky enough to receive poor family support or who has lost his or her biological family, should not be further neglected by the system and prevented from receiving PRTS care if that is the indicated need. Developing an aftercare resource becomes an important part of the plan of care. Trauma informed care also requires that the treatment reflects the child's past, provides effective trauma treatment, and insures safety, predictability, and stability of placement while intensive trauma treatment is provided. For a seriously traumatized child, focusing solely on stabilizing a child's behavior without providing intensive trauma treatment is not individualized, nor is it responsive to the needs of the child and family.

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Summary

Psychiatric residential treatment is an important and essential component of the mental health system of care. The best treatment programs are ecological in orientation and combine all the needed components to best help the child and family. Despite the fact that ecological treatment settings are not conducive to quantitative causal research designs, they have been shown to be some of the most effective services for children with multiple needs. Psychological treatment has shown decades of strong support across settings and has been shown effective when interventions in residential settings are considered rather than the setting itself. The family must be involved in both decision making and intensive treatment along with the child. If a child has lost his or her family for whatever reason, the child should not be further neglected by not receiving the level of intensive treatment services needed. The right target population should be afforded PRTS. Adhering to the historical criteria has shown that the right children receive the right level of care. Reliance on any one score, instrument or factor alone is contraindicated for PRTS as it is for any placement decision for a child. The admission decision on a child must be individualized with the needs of the family taken into consideration. The treatment must conform to the child and family and not expect the child to conform to the treatment. This includes both treatment programs as well as the overall system of care. When a PRTS program is carefully designed with multimodal treatments to address the complex needs of the child, and individualized in partnership with the family, this intervention can turn the most seriously challenging children in the system of care into some of the most improved consumers. Such an outcome is one that is desirable to all stakeholders in the system of care.

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APPENDIX C
Abt Associates Article

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Characteristics of Residential Treatment **For Children and Youth with Serious Emotional Disturbances**

By Abt Associates Inc.

**For the
National Association for Children's Behavioral Health (NACBH)
and the
National Association of Psychiatric Health Systems (NAPHS)**

Summer 2008



Abt Associates Inc.

Acknowledgements

NACBH, NAPHS, and Abt Associates wish to acknowledge and thank the key informants who gave their time and shared their perspectives as leaders in children's mental health advocacy, public policy, clinical research, accreditation, regulation, and financing of care.

NACBH and NAPHS would also like to thank their members for participating in a survey illustrating current practices in residential treatment programs. Most importantly, we would like to thank those who participated in the NACBH/NAPHS Work Group on Residential Treatment for their time, talent, and years of commitment to serving children, youth, and their families.

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Characteristics of Residential Treatment
For Children and Youth with Serious Emotional Disturbances

By Abt Associates Inc.

For the
National Association for Children's Behavioral Health (NACBH) and
National Association of Psychiatric Health Systems (NAPHS)

© Summer 2008.

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Executive Summary

Millions of American children and youth experience serious emotional and substance use disorders (*see chapter on "Prevalence"*). Of these, a critical percentage experience problems so severe, disabling, or complex that they require 24-hour out-of-home placement for treatment.

Many types of residential programs exist. How can the differentiation be made between the 24-hour services that provide *treatment* for children and youth with serious emotional disturbances and substance use disorders and those that only provide care and housing? The question is particularly timely as states, federal policymakers, payers, and others work to identify what services should be funded to meet the needs of youth with the most serious illnesses and how the programs should be defined and regulated.

Abt Associates was asked by the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS) to develop this paper to focus on the characteristics and role of a specific type of specialized treatment, residential.

This paper is intended to reintroduce state and federal policymakers and other key stakeholders to residential treatment programs as they are distinguished today from the many other types of residential programs - as a vital resource to attend to the unique needs of children and youth with serious enough and debilitating enough symptoms and diagnoses to require a structured, safe, and therapeutic out-of-home placement.

Conclusions

An Abt survey of members of the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS) indicates that the children and youth served by the NACBH and NAPHS residential treatment programs are clinically complex and functionally impaired, with multiple psychiatric diagnoses and co-occurring substance use, neurological, developmental, learning, medical, and other behavioral disorders.

Residential treatment is a treatment of choice, albeit a difficult one, when a young person is in need of a total 24-hour safe, structured environment to provide an array of appropriate and relevant services to address the severity of social, emotional, and/or behavioral disorders. As important as the admission criteria to assure clinical necessity is the need to assure for the child or youth that there is the therapeutic potential to benefit from treatment.

Residential treatment is an intervention, not a destination. It is a level of care in an array of services that children and youth, with or at risk of emotional or behavioral disorders, need at a particular time given their histories, diagnoses, complexities of impairment, and living and learning situations. It is a critical component of a system of care that some children need in order to have the chance to recover and regain their functioning in daily lives in the community as

productive participants at home and in school, safe and living with hope.

Policymakers and researchers agree that the optimal use of any one service in a comprehensive array of services in a system of care is highly dependent on the availability and capabilities of the other services in the system. When access to any service is limited, the system does not work as effectively as it could.

Introduction

Residential programs have a long history of service dating back to the 1700s. Residential treatment has evolved as the mental health service delivery system has grown.

As organizations representing substantial numbers of residential treatment programs, the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS) commissioned Abt Associates, Inc., to develop this report – with input and perspectives from multiple stakeholders – to inform discussions within states and communities and at the national policy level about residential treatment for children with serious emotional disturbance (SED) and other behavioral health conditions.

The need for the report was identified through a Residential Treatment Work Group convened in 2007 by NACBH and NAPHS. The Work Group, composed of both clinical and administrative leaders of residential treatment programs that belong to the two associations, identified areas for review and potential gaps in knowledge and information about residential treatment and the population served.

To inform the paper, relevant data were gathered from literature reviews, and key informant interviews were conducted to identify issues, problems, and practices. Abt Associates was asked to evaluate existing information on residential treatment leadership, policy, outcomes and innovation that may influence communities working to develop comprehensive systems of care, as well as recent federal policies assuring that residential treatment is an essential and integrated component of a full array of services. In addition, Abt conducted a survey of NACBH and NAPHS member organizations throughout the United States to gather program policy and practice data that correlate with the issues identified in the literature review and key informant survey.

Prevalence of Emotional and Substance Use Disorders in Children and Youth

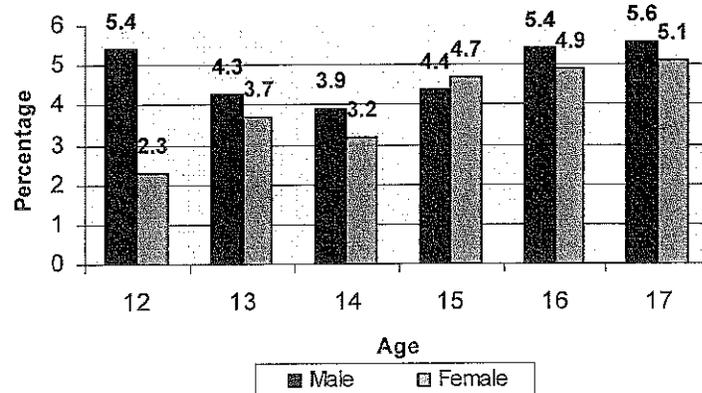
According to *Mental Health: a Report of the Surgeon General*, approximately 20% of the nation's children and youth are at risk for or have mental disorders (DHHS, 1999). Emotional disturbance and mental health conditions affecting as many as one in five adolescents require treatment, and about half of those adolescents have significant functional impairment as a result, according to the National Institute of Mental Health (NIMH, 2007).

Research findings indicate that young people experience many different types of problems, as noted in overall prevalence statistics in the Surgeon General's Report:

- mood disorders: 6.2% of children and adolescents aged 9 to 17, with 5% who have major depression and 1% who have bipolar disorder,
- depression: 10% to 15% of youth exhibit symptoms at any given time,
- psychoses: 1% of youth have bipolar disorder or schizophrenia,
- disruptive disorders: 10.3% of children and adolescents aged 9 to 17,
- substance abuse disorders: over 20% of youth with a mental health condition have co-occurring substance use conditions,
- anxiety disorders: 13% of children and adolescents aged 9 to 17,
- eating disorders: approximately 10% of youth, and
- chronic health conditions: an estimated 10% to 15% of children and adolescents have a chronic health conditions, frequently co-occurring with behavioral health conditions.

Table 1. Prevalence of Psychiatric Diagnoses (National Health Interview 2006)

National Health Interview: Mental Health Disorder Indicator Among Persons Aged 12 to 17, by Gender, 2006



The prevalence of these mental health conditions varies between male and female youths, as indicated in Table 1. Among those between the ages of 12 and 17, the discrepancy is greatest for 12 year old children, with more than double the incidence reported for boys.

According to the National Institute of Mental Health, while as many as 1 in 5 children and youth require some type of treatment, only about half of these (or 10% of all children), have significant functional impairment (NIMH, 2007). This translates into an approximate total of 4.3 million youth who suffer from a mental health or substance use condition that results in significant impairments at home, at school, with peers and in the community.

As published by the National Center for Children in Poverty (NCCP) in its 2006 Report on Children's Mental Health, about 5% to 9% of children and youth ages 6 to 17 have severe functional impairment in their ability to relate successfully to others within community based environments at home or at school (Dababnah and Cooper, 2006; Masi and Cooper, 2006).

Moreover, researchers identify "barrier behaviors", including extreme aggression, self injury and property destruction that effectively bar some of these children from meaningful integration with family, peers and at school (Isett et al. in McCurdy, 2004).

Conditions Can Be Life-Threatening

The national Youth Risk Behavior Survey (YRBS) conducted through the Centers for Disease Control and Prevention (CDC) estimated suicide attempts for a 12-month period in students in grades 9 through 12. For the year 2005, the YRBS found that:

- 17% of students reported seriously considering suicide,
- 8% reported attempting suicide, and
- 2% reported an injurious suicidal attempt.

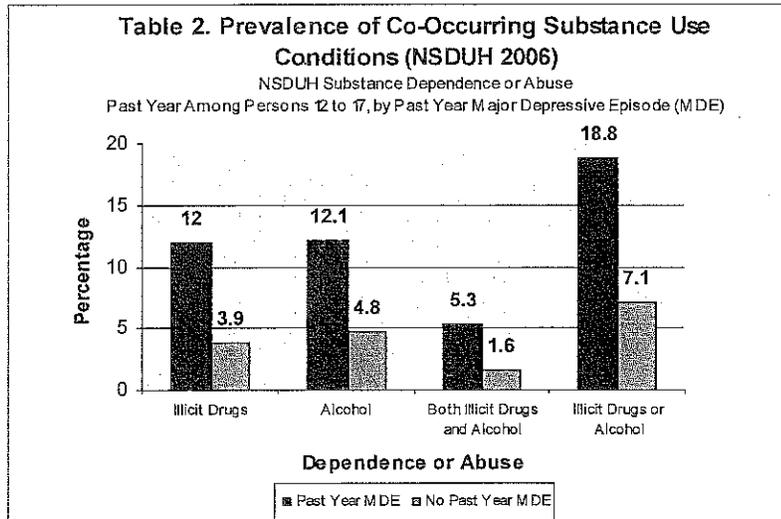
According to data provided by the Nemours Foundation, "Although suicide is relatively rare among children, the rate of suicide attempts and suicide deaths increases tremendously during adolescence." Suicide is the third-leading cause of death for 15- to 24-year-olds, according to the CDC, surpassed only by accidents and homicide.

Complexities Add to the Needs of Children and Youth with Serious Emotional Disturbances

Youth who have mental disorders are at higher risk for substance use. Table 2 below illustrates the results of the National Survey on Drug Use and Health (NSDUH) study revealing the higher rates of co-occurring substance dependence or abuse found among youth with a major depressive episode (MDE in the Table) compared to those without (NSDUH, 2006).

Research literature documents well the high risk of developing serious emotional disturbance, mental disorders, and co-occurring substance use conditions in the presence of multiple risk factors of poverty, violence, childhood abuse, homelessness, trauma of separation from families, exposure to alcohol

and drugs, and/or maltreatment (CDC, 2006). The most prominent research showing the health and social consequences of these risk factors is the Adverse Childhood Experiences (ACE) Study. The study was performed in collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego, tracking more than 17,000 Kaiser Permanente members between the ages of 18 and 83, and examining the links between their childhood maltreatment and their later-life health and well being.



"It has also demonstrated that the ACE score has a strong and graded relationship to health-related behaviors and outcomes during childhood and adolescence including early initiation of smoking, sexual activity, and illicit drug use, adolescent pregnancies, and suicide attempts. Finally, as the number of ACE increases the number of co-occurring or 'co-morbid' conditions increases" (CDC, 2006).

Societal Factors

While mental disorders affect children and youth from all cultural and economic groups, those from families experiencing poverty, illness, and/or crime are at a particular disadvantage. For example, children who have a parent with a mental illness are at a significantly greater risk for multiple psychosocial problems and have rates of diagnoses for behavioral health conditions that range from 30% to 50%, as compared to an estimated rate of 20% (cited above) among the total child population (Beardslee et al., 1996; Oyserman et al., 2000). Children and adolescents without strong family or community supports are at high risk of presenting in public systems other than mental health, including child welfare, juvenile justice, and education systems, which do not treat mental health disorders as their primary mission. An estimated 50% of children and youth in the child welfare system have mental health problems. Some 67% to 70% of youth in the juvenile justice system have a diagnosable mental health problem (Huang et al., 2005).

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The stakeholders interviewed by Abt conclude that residential treatment is an essential part of a robust array of services in an organized system of mental health care.

Children and Youth in Residential Treatment

Admission Criteria

Criteria recognized and used by clinicians and payers that trigger admission to residential treatment include:

- self injury and other danger to self
- physical aggression, assault and danger to others, and
- disruptive and destructive acts in the community.

Historically, admission to residential treatment has been based on three factors: 1) community protection, 2) child protection, and 3) benefits for the child, specific to residential treatment (Barker, 1982 in Burns et al., 1999). Though debate continues about the need for out-of-home placement, few clinicians will deny that residential treatment is appropriate for children with complex and intensive clinical needs and safety and protection requirements. These decisions should always be made with the input of families, educators, and other adjunct community systems as appropriate.

Medication Management

It is not uncommon for children and adolescents who are admitted to residential treatment programs to have been prescribed concurrently multiple psychoactive medications, sometimes more than one in the same class, prior to admission. Residential treatment offers a unique setting to be able to assess a child's medications. Often, inpatient stays are too brief to consider tapering a medication or medications. The outpatient setting is frequently not sufficiently containing to ensure a safe trial with medications. Residential stays provide a safe, structured environment to carefully reassess a child's medication regimen while other interventions are used to teach self-regulatory skills.

Snapshot of Current Practices

In an August 2007 survey, residential treatment programs throughout the United States provided a snapshot of their practices. The survey was administered electronically to the memberships of both the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS). A total of 91% of the associations' residential treatment members responded. The survey participants were licensed residential treatment programs throughout the United States.

The survey was intended to look at the conditions exhibited among children and youth admitted to their residential treatment, and the programs' staffing, service components, and key characteristics.

"Residential treatment remains a needed service for a small but significantly challenging group of children and adolescents."

(Stroul, 1996; Stroul & Friedman, 1996)
(Burns et al., 1999)

Residential Treatment Serves Youth with Serious Disorders

Children and youth in residential treatment present with multiple and complex needs. Diagnoses of children and youth admitted to NACBH and NAPHS treatment programs are cited in Table 3, below. Of those surveyed, the percentage of organizations that reported the following as “conditions exhibited among children admitted” is as follows:

- mood disorders – 91% of residential treatment facilities reported that they serve youth with mood disorders
- post traumatic stress disorder – 84%
- anxiety disorder – 80%
- alcohol and or substance use disorder – 70%
- psychotic disorders – 63%
- eating disorder – 34%

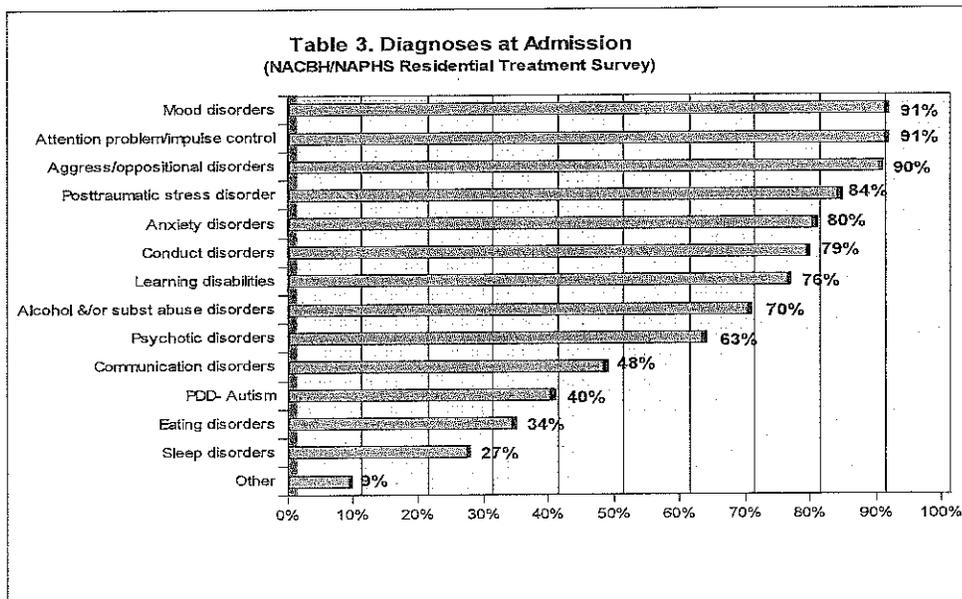
Neurological and other behavioral disorders that organizations reported as being exhibited in this population are:

- attention deficit/hyperactivity disorder/impulse control – 91%
- aggression/oppositional defiant disorder – 90%
- conduct disorder – 79%
- sleep disorder – 27%

Complex and complicating developmental and learning disorders that organizations reported as being exhibited in this population are:

- learning disorders – 79%
- communications disorders – 48%
- pervasive developmental disorder/autism – 40%

Another significant finding of the survey revealed that 25% of those surveyed reported that children and youth admitted to their programs have medical complications and physical disabilities.

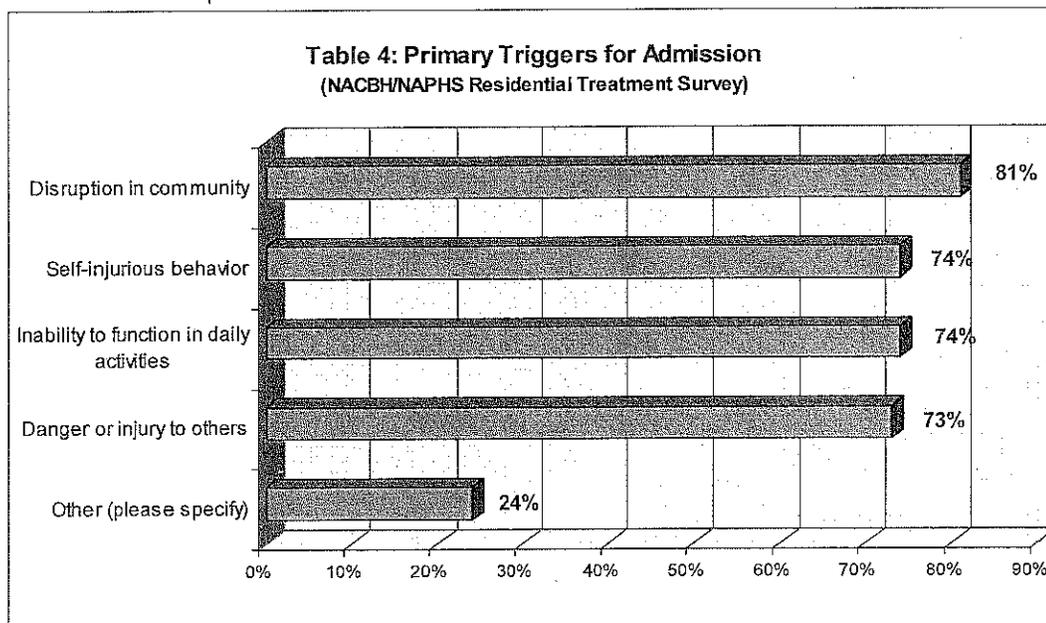


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Psychiatric Disorders Are Complicated by Other Factors

According to the survey, residential treatment programs responded that "barrier behaviors" exist as factors in admissions. Researchers define barrier behaviors as such problems as extreme aggression, self injury, and property destruction that effectively bar some of these children from meaningful integration with family, peers and at school (Isett et al., 1980; McCurdy). The results shown in Table 4 strongly suggest that multiple barrier behaviors, rather than any single factor, precipitate admission for these children to the majority of responding programs. Primary behaviors that contributed to admission, in rank order, include:

- disruption in the community
- self-injurious behavior
- inability to function in daily activities, and
- danger or injury to others.



The Challenge of Defining Residential Treatment

There is a need to differentiate residential treatment providers that operate in a highly regulated health care environment from those operating programs as disparate as boot camps, wilderness programs, boarding schools or homes providing for children's safety and well-being. While all may be labeled *residential*, not all provide residential *treatment*.

States have chosen to use diverse terminology to describe diverse residential facilities, adding to confusion. For example, a recent federal report on "State Regulation of Residential Facilities for Children with Mental Illness" identified 71 types of residential facilities reported by officials in 38 states.

All three national accrediting agencies – The Joint Commission, the Council on Accreditation, and The Commission on Accreditation of Rehabilitation Facilities – recognize the intensity of the type of residential treatment program described in this paper and provide national accreditation for residential treatment facilities.

"As others have noted (e.g., Fleishman 2004), the lack of standard definitions of key terms such as 'psychiatric residential facility,' 'residential treatment center,' and 'group home' have stymied efforts to develop a national statistical portrait of residential settings for individuals with mental illness. States have adopted widely discrepant terms for essentially similar institutional entities and, conversely, States operate facilities with similar names that provide markedly different sets of services and living environments. Important differences may exist between these institutions in terms of their specific target population and services provided, but knowledge of the official name of these facilities offers little insight into the nature of their differences. The diversity of names has impeded the development of standard categories of facilities for which national statistics could be developed."*
(Ireys, 2006)

** For example, residential settings with fewer than 16 children are called therapeutic group homes in Maryland and Hawaii, type I residential facilities in Ohio, level 1 residential treatment facilities in West Virginia, residential treatment facilities for youth in Alaska, and supervised independent living programs in South Carolina.*

Residential Treatment Definition

For purposes of this paper, the NACBH/NAPHS Work Group on Residential Treatment (see Appendix B) provided perspective and a definition of residential treatment for children and youth with serious emotional and substance use disorders. It stated:

Characteristics of Residential Treatment

Residential treatment is a specific level of care distinguished by the services and setting:

- *24-hour therapeutically planned behavioral health intervention*
- *highly supervised and structured group living and active learning environment where distinct and individualized therapies and related services are provided*
- *multidisciplinary team of clinically licensed professionals (including psychiatrists, psychologists, social workers, nurses, special education teachers, activity therapists, and others)*
- *diagnostic processes which address psychiatric, social and educational needs*
- *individualized assessment, treatment planning, and aftercare, involving the child and family*

The purpose is to help each child master the adaptive skills necessary to return to and function successfully in his or her community.

(NACBH and NAPHS Residential Work Group, 2007)

This definition was used by Abt Associates for interviews conducted with key informants to develop this paper.

The Work Group noted that residential treatment programs meeting this definition are governed by a variety of standards and regulations, such as:

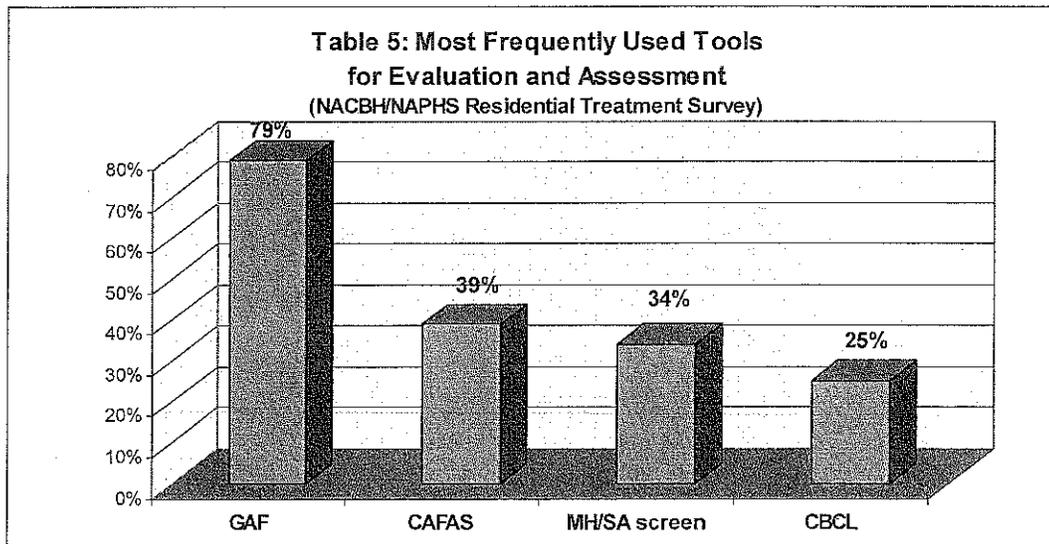
- licensure by appropriate state child-serving and regulatory agencies
- accreditation by nationally recognized accrediting agencies, including The Joint Commission, the Council on Accreditation (COA), and the Commission on Accreditation of Rehabilitation Facilities (CARF).
- certification by state Medicaid authorities.

Components of Residential Treatment

Assessment

NACBH- and NAPHS-member organizations reported in the August 2007 Residential Treatment Survey (Appendix C) that a number of standardized tools assist with evaluation, assessment, and treatment. The most frequently used tools are:

- the **Global Assessment of Functioning (GAF)**, which is a numeric scale used by clinicians to measure a child's overall level of functioning and carrying out of activities of daily living. The information is useful in planning treatment, measuring its effectiveness and predicting outcome.
- the **Child and Adolescent Functional Assessment Scale (CAFAS)**, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.
- the **Child Behavioral Checklist (CBCL)**, which is used by parents and others who know the child to rate the degree of problem behaviors and competencies.



The survey also reported the use of other selected measures, for both evaluation and planning treatment:

- Child Problem Checklist (CPC)
- Devereux Rating Scales
- Family Problem Checklist (FPC)
- Child and Adolescent Level of Care Utilization System (CALOCUS)
- Restrictiveness of Living Environment Scale (ROLES)
- Family Risk Scales (FRS)

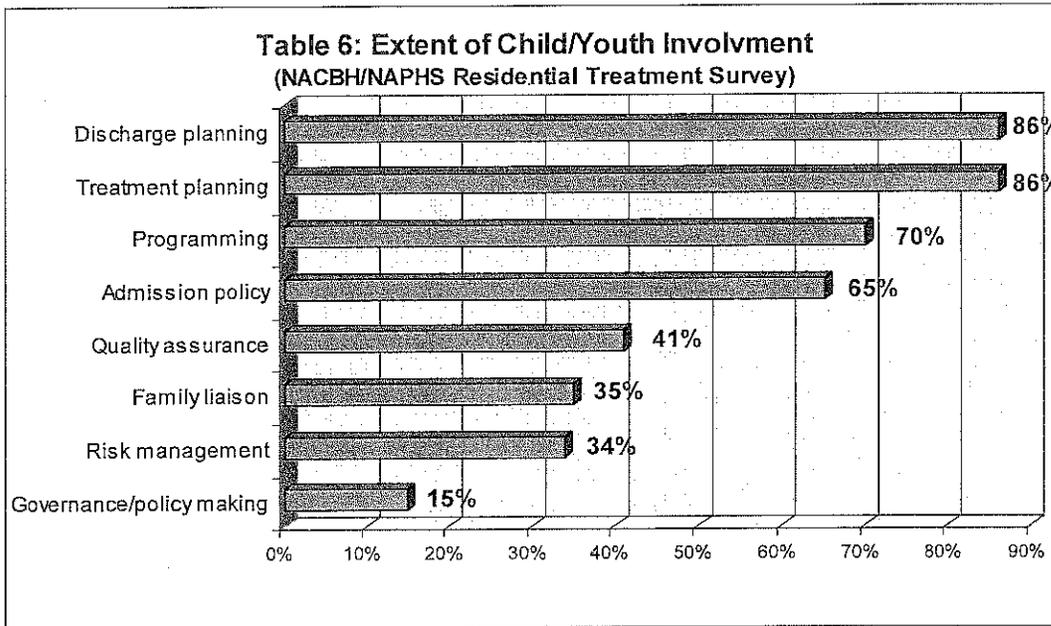
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Tools are often used in combination to strengthen the effectiveness of treatment according to written comments from the surveyed residential treatment programs.

Children and Families Are Involved

Individualized treatment planning that consistently and actively involves the child, family, and multidisciplinary team is a critical component and hallmark of residential treatment.

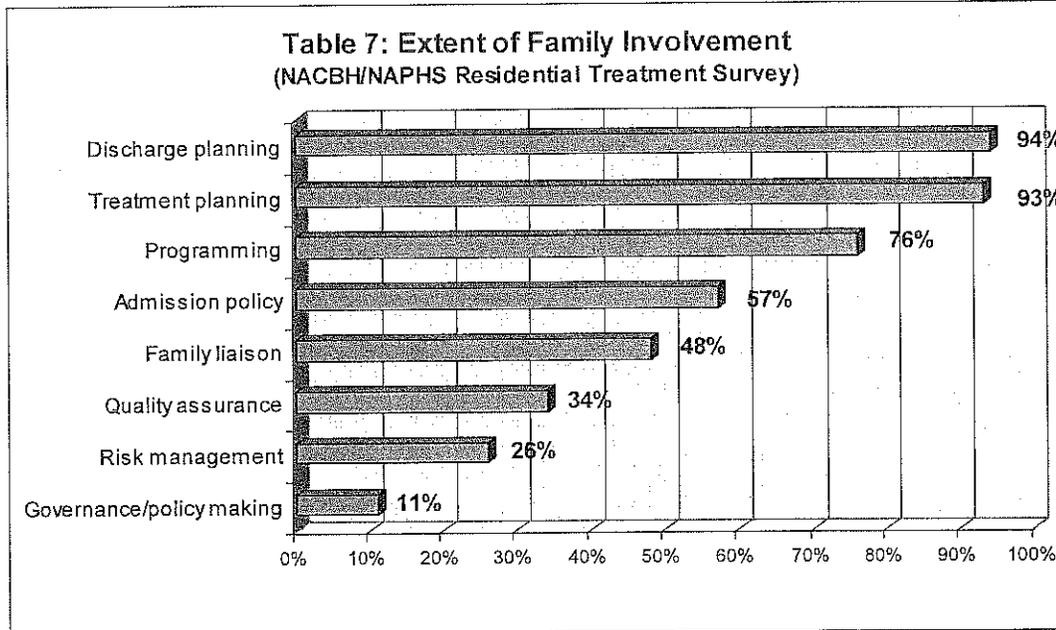
The survey found that the vast majority of responding residential treatment programs involve children and youth directly in discharge planning (85%), treatment planning (85%), programming (69%), admission policy (65%), quality assurance (41%), family liaison (35%), risk management (34%), and governance or policy making such as serving on boards or committees (15%).



It is widely understood and accepted that family involvement is central to effective treatment and care. "Families" for many youth in residential treatment may mean caregivers and advocates, such as social workers and court-appointed guardians. In the survey of NACBH and NAPHS member facilities, "family" was broadly defined as "relations and individuals who may include adults and children, parents and guardians, other relatives, and non-related individuals whom the client defines as family and who play a significant role in the client's life."

The survey found that family members are directly involved in discharge planning (94%), treatment planning (93%), admission policy (76%), programming (57%), quality assurance (34%), family liaison (48%), risk management (26%), and governance or policy making such as serving on boards or committees (11%).

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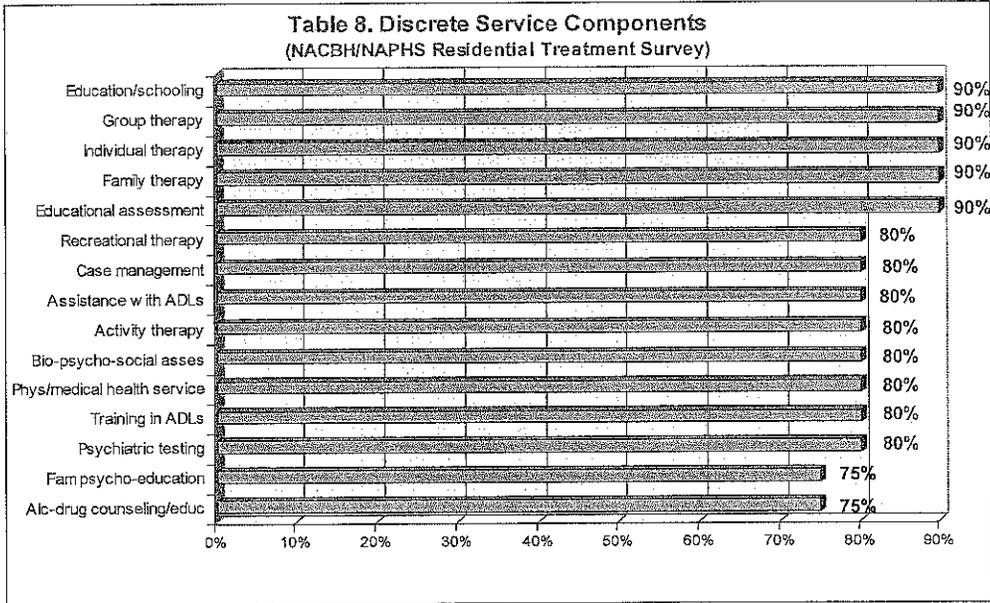


As child mental health services move in the direction of family-centered and child-focused care, residential treatment providers surveyed reported widespread use of family/parent satisfaction studies (used by 67%) and child satisfaction studies (used by 64%) to help inform practice.

A Comprehensive Array of Therapeutic Services

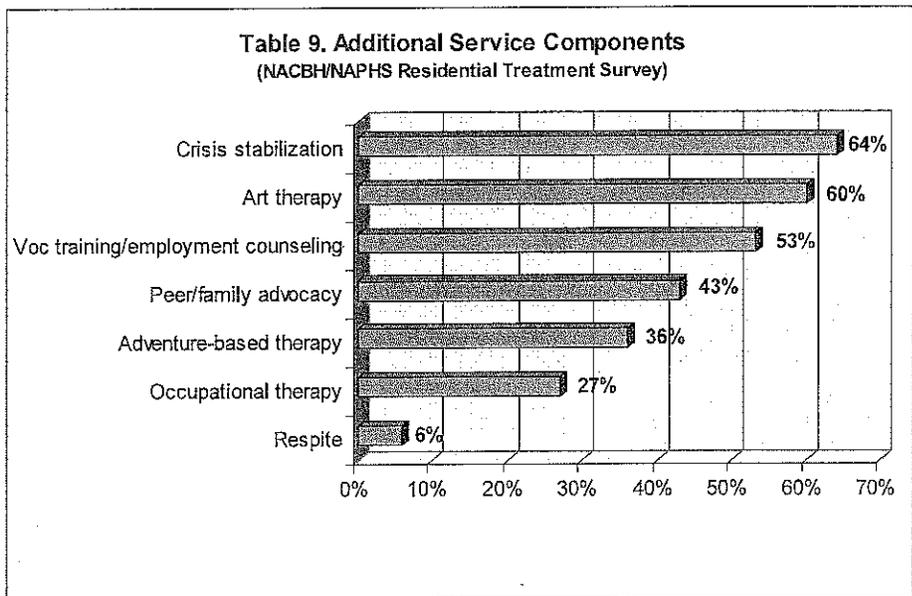
To be effective residential treatment requires the coordination and delivery of a comprehensive array of therapeutic services. Treatment involves individual and group therapies designed to address delays in cognitive, social, and emotional development, and education tailored to a child's grade level, learning style, and individual capabilities. Education is integral to the therapeutic day.

Respondents in the 2007 survey reported that they offer the services shown below within their residential treatment programs (Table 8).



The vast majority (more than 90%) provide education/schooling as well as group, individual, and family therapy. More than 80% provide educational assessment, recreation therapy, case management, assistance as well as training with activities of daily living, activity therapy, biopsychosocial assessment, physical/medical health services. Psychiatric testing, family psycho-educational services, and alcohol/drug counseling and education are also widely available services.

More than half also offered services such as crisis stabilization (64%), art therapy (60%), and vocational training/ employment counseling (53%). Many also offered services such as peer and family advocacy (43%) (Table 9).



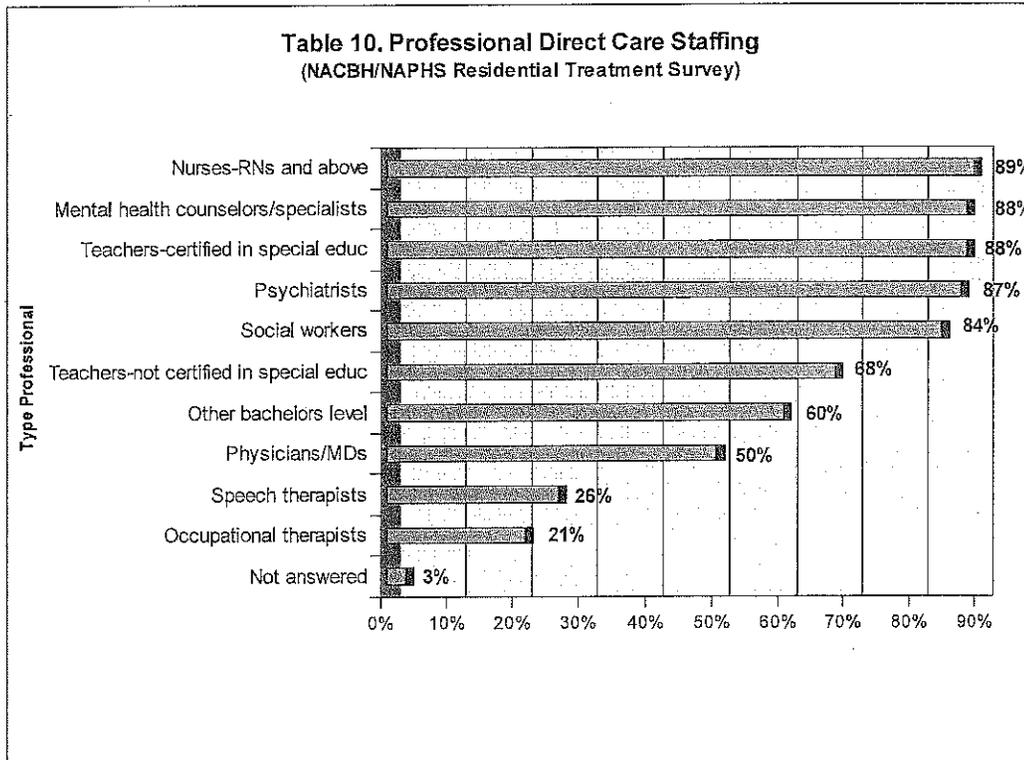
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In addition to residential treatment, many reported that they also provide other services such as day schools (offered in 59% of the responding facilities), outpatient services (44%), family support services (44%), day treatment (43%), and inpatient psychiatric services (53%). Some also offer services such as therapeutic foster homes (provided by 18% of respondents), partial hospitalization (18%), in-home services (17%), group homes (16%), individual foster homes (11%), respite care (11%), therapeutic group homes (9%), independent living (8%), and adoption (8%).

Multidisciplinary Teams

The residential treatment milieu is defined by having a wide range of professionals who are available under one roof. The mix of professional staffing in residential treatment is based on the specific clinical, developmental and educational needs of the individual child or youth. Treatment also includes medication management, family psychosocial education and treatment, vocational training, speech and language therapies, and a variety of other supports.

Facilities surveyed reported that they are staffed by highly skilled professionals bringing many perspectives to a comprehensive treatment plan. These teams include psychiatrists (in 87% of respondents), registered nurses or nurses with higher training (89%), mental health counselors or specialists (88%), teachers certified in special education (88%), social workers (84%) and other specialists.



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Why Communities Need Residential Treatment

As discussed, there exists a critical percentage of young people whose needs are so complex or disabling that they require intensive 24-hour out-of-home residential treatment.

Treatment of Choice for Some Children

"Residential treatment is not about the absence of alternatives, as currently perceived, but is the treatment of choice for some children."

(Key Informant, 2007)

Key informants concurred that delayed, insufficient and inappropriate treatments are costly, causing:

- clinical deterioration and dysfunction that are expensive to remediate
- irreparable harm to the children and youth themselves, or to others around them
- increasing involvement with social and juvenile justice systems, and
- educational delay, drop out, or failure.

The cost of limiting access to care – including residential treatment when needed – leads to:

- eventual underemployment or unemployment
- homelessness
- incarceration, and
- family burden and lost productivity.

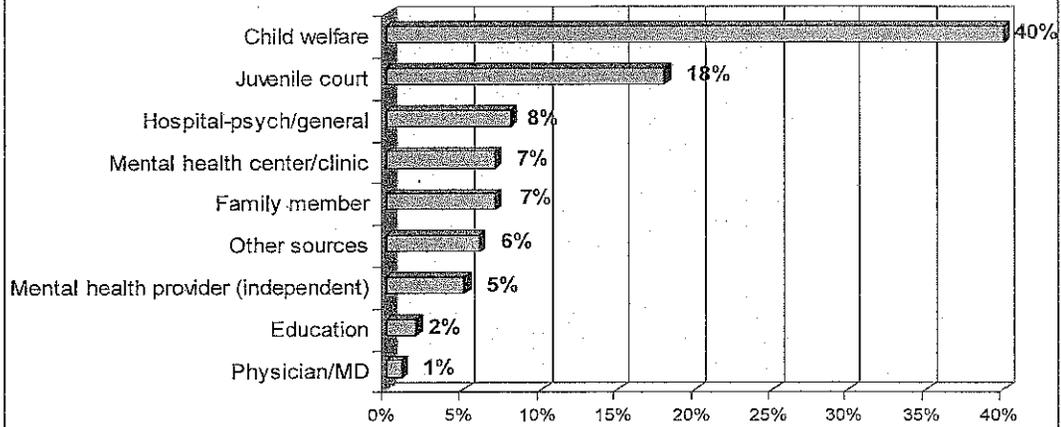
"Residential treatment often becomes treatment to undo the damage done by lack of adequate early interventions. Children come to residential treatment far later than advisable."

(Key Informant, 2007)

Children and Youth Enter Residential Treatment From Many Paths

Referral sources for residential treatment are as diverse as the process is complicated. Depending on the state, county or locale in which they live, children and youth enter residential treatment through schools, primary care providers, hospitals, community mental health centers, welfare agencies, juvenile justice systems, the courts or their families.

Table 11. First Ranked Referral Sources
(NACBH/NAPHS Residential Treatment Survey)



Families See a Need

Families and other caregivers of children and youth with serious emotional disturbances and substance use disorders cited several factors that are important to them in making the difficult decision to seek treatment in an out-of-home setting:

- complexity of their child's needs
- challenges in accessing care
- importance of finding clinically competent programs to keep their children safe
- need for a structured, 24-hour milieu to manage their children's needs
- need for medication evaluation and management
- importance of engaging parents in admission, treatment, and discharge decisions, and
- desire for all the components of treatment and care to be aligned in a manageable system.

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Family Vignette

"As a physician whose child has serious emotional disturbance with co-occurring conditions, I was stunned at how difficult it was to find accurate information from public sources as well as from respected behavioral health colleagues on the existence or availability of intensive treatment programs to meet my child's escalating needs. The time wasted and risks posed by barriers to the right treatment at the right time, to trials in inappropriate services, were disheartening and dangerous. We finally hired a private consultant to search on our behalf. What happens to families with fewer means?"

(Family Member, 2008)

About the Organizations

Abt Associates, Inc., founded in 1965, has conducted social policy research for 40 years. The firm has both a substantial portfolio of work related to Medicare, Medicaid, and commercial insurance and a large behavioral health practice. Principal authors of this report are Danna Mauch, PhD, Gail Robinson, PhD, and Ariane Krumholz, MSPH.

Danna Mauch, PhD, a Principal Scientist/Associate at Abt Associates, is based in Cambridge, MA and has more than 30 years of experience in designing, implementing and managing research, clinical and administrative services in the behavioral health arena. Her original experience, gained throughout the 1970s, was in residential treatment developed in the context of emerging community based care systems. She held positions as counselor, psychologist, program director and executive director for a variety of programs serving children and adults with behavioral disorders in residential treatment programs funded by state departments of mental health, mental retardation and juvenile justice. The focus of her work as a state mental health director, managed care executive and consultant has been on integration of systems of care, financing, and management information.

Ariane Krumholz, MSPH, is a Senior Associate at Abt Associates Inc., Cambridge, MA. Her work is focused on consulting to state and federal agencies on redesign and unification of care systems. Prior to joining Abt, she held planning executive positions for behavioral health in vertically integrated health care systems and was executive director of a community health center and plan.

Gail Robinson, PhD, is a leading expert in mental health policy and a Vice President in the Washington, D.C. office of Abt Associates. She has more than 25 years' experience in health and behavioral health issues at the national and State levels, particularly in the area of service delivery and financing. She applies her technical expertise in evaluation and health services research to solving policy and implementation problems.

The National Association for Children's Behavioral Health (NACBH) works to promote the availability and delivery of appropriate and relevant services to children and youth with, or at risk of, serious emotional or behavioral disturbances and their families. NACBH members are multi-service providers of mental health and substance abuse treatment, family and child services and supports, educational and juvenile justice programs. With roots in mental health, child welfare, education, or juvenile justice arenas, all are committed to creating responsive systems of care for children and families dealing with emotional and behavioral disturbances.

The National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective

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prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Its members are behavioral healthcare provider organizations that own or manage more than 600 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. The association was founded in 1933. Through its Youth Services Committee, NAPHS works to promote the need for behavioral health treatment, education, and rehabilitation services for troubled youth; to get more visibility for youth services; and to raise youth services on the national agenda.

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Appendix A

Key Informants

Key informants interviewed by Abt Associates for this paper included researchers, clinical experts, national accrediting body executives, policy experts, state healthcare leaders, federal agency leaders, academicians, association executives, and family/consumer leaders.

Individuals were selected for their professional and/or personal experiences with residential treatment, national and state perspectives on system-wide issues impacting the delivery of behavioral healthcare services for youth.

Interviews were conducted by Abt Associates throughout 2007.

Chris Bellonci, MD, The Walker School

Gary Blau, PhD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Barbara Burns, PhD, Duke University

Mary Cesare Murphy, PhD, The Joint Commission

Janice Cooper, PhD, National Center for Children in Poverty

Henry Ireys, PhD, Mathematica Policy Research

Chris Koyanagi, MA, Bazelon Center for Mental Health Law

Stephen Mayberg, PhD, California Department of Mental Health

Sandra Spencer, National Federation of Families for Children's Mental Health

Beth Stroul, PhD, Management & Training Innovations

Appendix B

Work Group on Residential Treatment – 2007

April 11, 2007

**NACBH / NAPHS Joint Meeting with Abt Associates, Inc.
(and other NACBH/NAPHS project advisors)**

Pat Connell, RN, MBA, CHE, CBHE, CIP
Director
Girls & Boys Town Behavioral Health Division
Omaha, NE

John Damon, PhD
NACBH Board
Chief Operating Officer
Mississippi Children's Home Services
Jackson, MS

Leonard F. Dziubla, ACSW, CHE
(NAPHS Youth Services Committee)
CEO
Phoenix Care Systems, Inc.
Milwaukee, WI

Vickie Lewis
Chief Executive Officer
La Amistad Residential Treatment Center
Maitland, FL

Ray Luccasen
(NAPHS Youth Services Committee)
Vice President & Chief Clinical Officer
Youth & Family Centered Services
Birmingham, AL

Denis McCarville
NACBH Treasurer and Past President;
President
Uta Halee Girls Village and Cooper Village
Omaha, NE

Diana Ramsay
(NAPHS Youth Services Committee)
Executive Vice President & COO
Sheppard Pratt Health System
Baltimore, MD

Beverly Richard
Sr. V-P for Program Development
Three Springs, Inc.
Huntsville, AL

Elliot Sainer
(NAPHS Youth Services Committee)
Vice Chairman
CRC Health Group
S. Pasadena, CA

Robert P. Sheehan
NACBH Director and Past President
President and CEO
Boys and Girls Home and Family Services
Sioux City, IA

Fran E. Wilson, PhD
Senior Vice President & Chief Clinical Officer
Devereux
Villanova, PA

Sharon Worsham
CEO
Shadow Mountain Behavioral Health System
Tulsa, OK

ABT ASSOCIATES, INC.

Danna Mauch, PhD
Principal Associate/Scientist
Cambridge, MA

Gail Robinson, PhD
Vice President
Abt Associates
Bethesda, MD

Ariane Krumholz, MSPH
Senior Associate
Abt Associates
MA Department of Mental Health
Central Office
Boston, MA

STAFFS:

NACBH:
Joy Midman
Executive Director

Pat Johnston
Director Member Services

NAPHS:
Mark Covall
Executive Director

Kathleen McCann, RN, PhD
Director of Clinical and Regulatory Affairs

Carole Speak
Director of Operations & Communications

Nancy Trenti, JD
Director of Congressional Affairs

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Appendix C

About the Survey of Residential Treatment Programs

Using a collaborative approach with the Residential Treatment Work Group consisting of members of NACBH and NAPHS, Abt Associates, Inc. designed a nine-question on-line survey on residential treatment for children and youth. The goal of this survey was to gather information on key characteristics of the NACBH and NAPHS residential treatment programs, including: demographics, referral patterns, admission criteria, staffing, quality and outcomes measurements, and program components.

The survey participants were licensed programs from throughout the United States.

The survey was administered electronically to the memberships of both NACBH and NAPHS. A total of 91% of the associations' residential treatment members responded.

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55 Wheeler Street
Cambridge, MA 02138
Phone: 617/492-7100
Web: www.abtassoc.com

National Association for Children's Behavioral Health
1025 Connecticut Avenue, NW, Suite 1012
Washington, DC 20036
Phone: 202/857-9735
Web: www.nacbh.org

National Association of Psychiatric Health Systems
701 13th Street, NW, Suite 950
Washington, DC 20005
Phone: 202/393-6700
Web: www.naphs.org

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APPENDIX D

Resumes

000074

Allan D. Barnes
19 Ivy Lane, Waterbury, CT 06705
Cell Phone (860) 420-8345 • abarnes26@gmail.com

Objective

To obtain a position providing direct care and support as a counselor for adolescent children who have emotional and/or behavioral disorders

Education

August 2003-present **University of Connecticut, Storrs, CT**

- Bachelor of Science, Liberal Arts & Sciences
- Major: Human Development & Family Studies
- Degree expected to be received upon completion of one final course

Relevant Courses

Individual & Family Development	Adolescent Development
Family Interaction Processes	Drugs and Society
Family Pathology	Deviant Behavior
Family Violence	Introduction to Counseling
Public Policy & the Family	Diversity Issues in Human Development & Family Studies

Experience

September 2007-March 2008 **Waterbury Youth Service System, Inc., Waterbury, CT**

- Child care specialist
- Provided direct child care services for children in the custody of the Department of Children and Families and living in a safe home with other children who were removed from their homes; children ranged in age from infancy through adolescence
- Documented details of the children's days, including observed atypical behavior patterns and/or significant events that a child may have reported regarding their history of abuse/neglect

August 2007-March 2008 **Alliance Staffing of CT, LLC, Cheshire, CT**

- Mentor
- Carried out behavior management plans developed by the child's social worker. Examples of goals include appropriate behavior in the community and anger management during sports.
- Facilitated de-escalation during moments of crisis
- Documented child's behavior during activities and response to support provided, as well as significant behavioral observations of the child and/or comments reported by the child

January 2007-May 2007 **University of Connecticut, Storrs, CT**

- Intern counselor
- Facilitated discussions with freshmen students about the challenges involved in the transition to college. Also, brainstormed and discussed ways to cope with these transitions.
- Presented in front of groups of 15-20 students about the dangers of drugs and alcohol
- Counseled undergraduate students who had previously been involved with drugs, alcohol, and other unlawful issues

(Continued on back page)

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September 2003-May 2007

University of Connecticut, Storrs, CT

- "Big Brother"
- Participated annually, as the opportunity was extended to the University of Connecticut Football Team
- Served as a mentor and positive role model for an adolescent child to which I was assigned to spend the day. Children involved were typically interested in sports and we discussed the importance of school in reaching these sports-related goals.

Activities

August 2003-May 2007

University of Connecticut Football Team, Storrs, CT

- Co-captain of the University of Connecticut Football Team- 2006
- Actively participated on the team as a cornerback and safety for four years
- Motor City Bowl Championship- 2004
- Participated in volunteer opportunities extended to the team, such as Big Brothers, as well as visits to Connecticut Children's Medical Center in Hartford, CT to spend time with patients

References

Available upon request

000076

10/8 @ 5:00 - message at 6:11 - 2721 + 922-5191
scheduled for 10/15 @ 12:00

Jessica Bali, RN

7 Nod Brook Drive
Simsbury, CT 06070
Jessieb123@aol.com
(860) 658-2721 or (860) 922-5191

OBJECTIVE:

To care for a variety of patients as a registered nurse, utilizing my education and nursing skills to make a positive impact.

EDUCATION:

Associate's Degree in Nursing, 2008, Goodwin College, East Hartford, CT
President's List, Deans List; GPA 3.56/4.00

Bachelor of Arts, 2003, University of Connecticut, Storrs, CT

CERTIFICATIONS:

Registered Nurse License # 087982
EMT-B Certification 2004-2007 CPR Certification (Current)

CLINICAL ROTATIONS:

New Britain General , New Britain, CT	Fall 2008
Hospital for Special Care , New Britain, CT	Summer 2008
Bristol Hospital , Bristol, CT	Summer 2008
Bradley Memorial , Southington, CT	Spring 2008
St. Francis Hospital , Hartford, CT	Fall 2007
Duncaster Caleb-Hitchcock Facility , Bloomfield, CT	Summer 2007

WORK EXPERIENCE:

Child Care Provider 1993-present
Provide child care for two families. Cook, clean, drive children to activities and tutoring.

Private Swim Instructor 1997-2008
Miss Jess's Private Swim, Simsbury, CT
Owned and operated a private swim lesson business teaching an average of 60 students per summer. Students varied in a wide range of ages, skills and disabilities.

Substitute Teacher 2004-2008
Simsbury Public School System
Taught grades K-12, managed classrooms and carried out lesson plans. Also taught art, music, gym and special education in resource rooms.

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MARIA HELENA BOTERO – RN
9 Ginger Dr, West Hartford CT, 06110
860 233-6505 (H) majucar@sbcglobal.net

OBJECTIVE

To pursue a career in nursing that will utilize my professional, medical and personal abilities and support my desire to provide high quality care, support, and enrichment to patients' lives.

EDUCATION AND LICENSURE

Capital Community College, Hartford CT
Associated Degree Nursing
Honors: Cum Laude
License No. 094666 State of Connecticut

Universidad Cooperativa de Colombia
Bachelor's Degree - Business Administration 1992 -1998

EXPERIENCE AND WORK HISTORY

CLINICAL ROTATION

Spring 2010: Hartford Hospital, Surgical floor. MiddleSex Hospital, Intermediate Care Unit.
Institute of Living on Hartford.

Fall 2009: Hartford Hospital, Cardiac floor. MiddleSex Hospital, Surgical floor.

Spring 2009: Hartford Hospital, Surgical floor. Manchester Hospital, OB.

Fall 2008: Bristol Hospital, Surgical floor.

1995-1998 Variedades Fenix
Self - employed. Operation of a jewelry retail business included buying from vendors, supervising and managing employees, and providing customer service.

1994 Holanda, Colombia
Book Keeper. Processing and maintaining of payroll, personal records, and maintaining and balancing financial accounts.

1992-1993 Instituto de Cancerologia, Colombia

200078

Administrative Assistant. Scheduling patient appointments, filing of patient documents, managing cash and related paperwork, medical billing, responsible for inventory of medication and providing personal assistance and support to patients.

1990-1992

Esso Colombiana Ltda

Receptionist, Administrative Assistant. Performed administrative duties such as scheduling appointments, filing, distributing the appropriate payments to corresponding recipients, and directing the distribution of products through communication with companies and invoice forms.

COMPUTER PROFICIENCIES

Windows XP, Word, Excel, Power Point, Access, Publisher

LANGUAGES

Fluent in Spanish and English

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Theresa Carbone

319 Hitching Post Lane
Windsor, CT 06095

860-688-5761
tcerbone@comcast.net

Experience

2005 - 2006

Catholic Charities

New Britain, CT

UCONN Field Education Intern for MSW Program

- Outpatient services provided for adult clients.
- Mental health, substance abuse, and anger management evaluations.
- Individual mental health counseling of adults.
- Develop treatment plans and initial diagnoses.
- Facilitate substance abuse group sessions.
- Work with diverse populations and low socio-economic conditions.

2004 - 2005

Farmington Community Services

Farmington, CT

UCONN Field Education Intern for MSW Program

- Nine ongoing cases with adults and children.
- Planned a series of workshops with speakers that centered on family issues.
- Participated in activities that promoted elderly and youth interactions.
- Planned and presented a de-stress workshop for adults.
- Organized and planned teen activities for middle and high school children called Safe Solutions for Teens to combat substance abuse.
- Facilitated a grief group for those who have recently lost loved ones.
- Organized a luncheon to introduce PTO/PTA presidents to available services.
- Form a group for single people with mental health issues.
- Attended various workshops on topics such as Death and Dying, Suicide Prevention for the Elderly, Successful Aging, Out of the Box for Life, Child Abuse – a Multi-System Approach, and Anxiety.

1997 - 2004

Clover Street Elementary School

Windsor, CT

Paraprofessional

- Worked at every grade level mentoring children and counseling social skills.
- Helped children with their reading, writing, and math skills.
- Supervised children in the classroom, cafeteria, and transportation areas.
- Staff Member of the Year in 1999.
- Member of many committees for improving educational processes.
- Coordinated fund-raisers to improve school spirit.

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Experience (con't)

- 2000 - 2003 Special Education PTA Windsor, CT
- President and Founder**
- Founded the Windsor Special Education PTA and served as president for the initial two year term.
 - Increase awareness among teachers, staff, and the community of children with diverse needs and learning skills.
 - Support and educate families and students of their rights to an appropriate education regardless of ability or disability.
 - Wrote and supervised a grant from McDonald's to fund a middle school reading program.
 - Involved in the Windsor school budget process.
 - Recruit members, organize volunteers, manage programs, and coordinate committees that address specific functions within the organization.
- Summer, 2000 Council of Int'l Education Exchange Windsor, CT
- Teacher**
- Taught and mentored a class of Spanish students for a six week period.
 - Planned a curriculum of classroom recitation and cultural activities.
 - Supervised field trips and exchanged and compared information about religion, traditions, schools, amusements, and other cultural issues.
 - Taught and developed activities related to the English language.
- Summer, 1999 Sage Park Middle School Windsor, CT
- Tutor**
- Worked a summer school CMT program for middle school students
 - Tutored an 8th grade student for remedial reading.
- 1995 - 1999 Learning Disability Association Connecticut
- Advocate**
- Advocated for students with regard to their special education needs.
 - Taught parents how to advocate for their own children.
 - Completed six month advocacy program with the LDA to become a parent assistor.
 - Served 18 months with the LDA as a parent assistor.
 - Formed FACES - Family Advocates for Children's Educational Success - a parent group for children with learning disabilities and special needs.
- 1995 - 1998 Poquonock School PTO Windsor, CT
- President**
- Planned and coordinated various fund-raising and student activities.
 - Organized and supervised meetings among members and school personnel.
 - Involved in the budget process.

000081

Experience (con't)

- | | | |
|-------------|--|-------------|
| 1990 – 2002 | St. Joseph's Church
CCD Teacher
• Taught from 3 rd grade through confirmation during 10 th grade and back again. | Windsor, CT |
| 1978 – 1981 | Combustion Engineering
Office Administrator
• Planned travel arrangements and maintained schedules for twelve professionals in an industrial supply management environment.
• Organized all aspects of the office, prepared correspondence, reports, and presentations.
• Prepared meeting agendas and kept track of critical notes and agreements. | Windsor, CT |
| 1973 – 1977 | Medical Secretary
• Dr. Douglas Stewart, DDS, Hingham, MA
• Dr. Marvin Kessler, Orthodontist, Troy, NY | |

Education

- | | | |
|-------------|---|-------------------|
| 2004 – 2006 | UCONN School of Social Work
• Masters of Social Work, Summa Cum Laude | West Hartford, CT |
| 2002 – 2004 | Bay Path College
• B.S., Liberal Studies, Magna Cum Laude | Longmeadow, MA |
| 1971 – 1973 | Hudson Valley Community
• A.S., Medical Secretarial Science | Troy, NY |
| 1997 & 2002 | New Horizons Training Center
• 1997 - Eight courses in basic computer skills, Word, and Excel.
• 2002 - Microsoft Word 2000 Level 1 | Windsor, CT |

Professional Development

- | | | |
|------|--|---------|
| 2006 | • PRAXIS-I Exam | Passed |
| | • State of CT, Department of Education Certification | Pending |
| | • Plan to obtain LICSW in the future | |

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319 Hitching Post Lane
Windsor, CT 06095
May 23, 2006

Yvette Young, Senior Program Director
Eagle House – Sub Acute Residential Program
The Village for Families & Children, Inc.
1680 Albany Avenue
Hartford, CT 06105

Dear Ms. Young:

This letter is in response to your job posting entitled "Social Worker II or III for the Sub-Acute program at the Eagle House. I am very interesting in this position as I particularly enjoy and love working with children in a very diverse environment. I am a culturally competent clinician, who respects and understands a cultural competent practice. I am very dedicated in assisting children in realizing their strengths and attributes, while also helping them compensate for their weaknesses. My positive connection with children adheres to my philosophy of using a strength based approach.

As you can see from my resume, I have many life experiences as a mother of four, as well as years working with children and families in the school system in support, advocacy and beyond. In addition, I am a recent graduate of the University of Connecticut School of Social Work, in which children inspired me to go forward and pursue this particular career. I am a casework major, pursuing future licensure, and have experience in the therapeutic setting conducting individual counseling, mental and substance abuse evaluations, as well as facilitated a substance abuse group. One of my strengths is my interpersonal skills where I am able to positively engage with the client. I am a team player and work well collaboratively with others. In addition, I enjoy children tremendously in any setting.

I feel I would be an asset to your agency and would love to discuss this further if there is a mutual interest. Please call me at 860-688-5761 at your earliest convenience. I look forward to hearing from you.

Sincerely,



Theresa Cerbone
MSW

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TAMARA BUTLER

(860) 242-3953

139 East Harold St.

Bloomfield, CT 06002

butler2005_tamara@yahoo.com

OBJECTIVE: To obtain a position as a Case Manager that will utilize my experience working in the Social Service sector.

SUMMARY OF QUALIFICATIONS:

5 years experience working with inner-city youths counseling and providing various services.

WORK EXPERIENCE:

9/04-11/04 @ Wireless East Harford, CT

Customer Service

- Reconciled register daily at store opening to ensure accurate money counts
- Kept inventory counts on product accessories and merchandise
- Assisted customers with inquiries on products and services as well as operated computerized cash register

6/03-7/04 Hartford Neighborhood Centers, Inc. Hartford, CT

Program Assistant

- Tutored inner-city youths ages 6-15 on basic academics
- Planned daily menus for children as well as cooked and prepared meals adhering to nutritional guidelines
- Informed parents daily on progress of child behavior and to let the parents know that their child did not bring homework to the program

2/03-4/03 New York and Company Waterbury, CT

Sales Associate

- Received, tagged and hung incoming merchandise
- Processed customers cash, credit card and check payments
- Provided customers with personal selections and purchases

EDUCATION:

1/05 SAND/STRIVE Hartford, CT

Job Readiness
Certificate Achieved

5/03 Teikyo Post University Waterbury, CT

Management Information Systems
Bachelor of Science

5/01 Mitchell College New London, CT

Business Management
Associate Degree

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JENNIFER DYAL
(860) 874-4010
109 Avery Street
Manchester, CT 06042
Jenniferd1023@yahoo.com

OBJECTIVE: To obtain a position as a therapist, social worker and/or program coordinator working with individuals and/ or families.

EDUCATION

Springfield College, Springfield, MA
Master of Social Work, School of Social Work
Concentration: *Advanced Generalist Practice*

May 2009

Bachelor of Science in Human Services, School of Human Services
Graduated Magna Cum Laude

December 2006

SUMMARY OF QUALIFICATIONS

- Two years experience working with adolescents and families
- Work well as a member in an interdisciplinary team
- Served as social worker in wide range of situations, utilizing skills in: short/long term counseling; crisis intervention; phone counseling; family counseling; bereavement counseling
- Excellent verbal and written communication skills
- Committed to bringing about real, practical results in people's lives

SOCIAL WORK EXPERIENCE

Psychiatric Social Work Trainee/ Intern
Community Child Guidance Clinic, Inc., Manchester, CT

September 2008 - May 2009

- Provided individual and family therapy treating voluntary and involuntary clients in an outpatient setting
- Completed investigative intake interviews and diagnostic evaluation
- Completed DSM IV multi-axial I-V diagnosis
- Developed and implemented treatment plans in keeping with the focus of the patients' needs and resources
- Referred and recommended clientele to appropriate community-based resources
- Specialized in emotional, social, behavioral and academic problems
- Provided crisis intervention and problem solving on a daily basis
- Provided comprehensive discharge planning and continuing care plans
- Maintained collaborative relationships with family members and other service providers
- Maintained effective and organized case management

Social Work Intern
Bellizzi Middle School, Hartford, CT

September 2007 - April 2008

- Provided individual counseling sessions to students in grades six through eight
- Co-developed and facilitated psycho educational and therapy groups: Loss and Separation for Adolescents with Incarcerated Loved Ones, Leadership Skills
- Developed individualized needs and goals assessments and completed psycho-social assessments of clients
- Worked in as a member in an interdisciplinary team
- Completed thorough and detailed case management
- Advocated for clients with regard to academic and behavioral needs to assure highest quality of services
- Completed consultations with parents, teachers and community-based agencies
- Participated in development of behavioral modification plans and Functional Behavioral Assessments (FBA)
- Participated in Planning Placement Team meetings (PPT), and in developing Individual Education Plans (IEP)
- Counseled and de-escalated situations while providing crisis intervention services

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RELATED EXPERIENCE

Family Counselor

March 2007 - Present

Salvation Army, Marshall House, Hartford, CT

- Provided direct care and supervised the physical and psychological welfare of individuals in a residential setting
- Worked with homeless families, youth, single mothers, single fathers and elderly populations
- Served clients from a wide range of ethnic backgrounds; sensitivity and knowledge of cultural/ethnic issues
- Completed telephone screening assessments and intake interviews, selecting appropriate clients for the program
- Referred clientele to appropriate community-based resources and services
- Counseled clientele on a short-term basis, applied crisis intervention techniques and skills when appropriate
- Documented detailed information on a daily basis in clientele case notes
- Completed mandatory city census reports
- Administered and monitored medications

ADDITIONAL EXPERIENCE

Social Work Graduate Assistant

June 2008 - May 2009

Springfield College School of Social Work, Springfield, MA

VOLUNTEER WORK

Victims of Crime Assistance (VOCA) Volunteer

September 2008 – May 2009

Community Child Guidance Clinic, Inc., Manchester, CT

- Served as a volunteer in a grant-funded program supporting victims of violent crimes including physical and sexual abuse, homicide, robbery, assault, and domestic violence
- Provided individual therapy and family therapy
- Supported and advocated for children and families who have been victimized by violent crimes
- Provided referral services for clientele to community-based resources
- Managed a domestic violence case
- Organized and distributed annual Satisfaction Analysis survey

PROFESSIONAL DEVELOPMENT

- National Association of Social Workers – Member 2009 - Present
- "*Best Practices in Suicide Prevention and Intervention with Adolescent and Young Adults*" Conference, Springfield College School of Social Work, Springfield, MA Spring 2008

RELEVANT CERTIFICATIONS /COURSEWORK

- Severe and Persistent Mental Illness Spring 2009
- HIPAA Training Fall 2008
- Contemporary Challenges in Child Welfare Fall 2008
- CPR Adult, CPR Child, CPR Infant, First Aid Summer 2008

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AKILAH FULK, RN
4 Stoneycrest Drive, Middletown, CT 06457
(860) 597-4435 / akilah79@yahoo.com

~ Registered Nurse ~

QUALIFICATIONS

- Eight years of experience in mental health, including administering medication. Taught patients about side effects and instructed them on which ones to report immediately.
- Proven ability to manage and create personal care for patients with little or no directions.
- Demonstrates the ability to acclimate within various organizations working independently or within a team.
- In-depth understanding of medical terms, parameters and implementation of interventions.
- Excellent rapport with patients, families and co-workers.
- Verifiable track record of success in classroom, practicum and clinical.
- Extremely organized and flexible; team player; committed to get the job done.

EDUCATION

Associate Degree of Nursing , Capital Community College, Hartford, CT	2007 - 2009
Social Work , Norfolk State University, Norfolk, VA	2000 - 2002

PROFESSIONAL EXPERIENCE

Clinical Rotations:

Hartford Hospital, Institute of Living, Connecticut Children's Medical Center, Hartford, CT
Manchester Memorial, Manchester, CT

Student Nurse

10/07 - 05/09

Demonstrated nursing process to ensure delivery of safe patient care. Incorporated teaching with each intervention while assessing patients level of understanding to material provided. Utilized principles of autonomy within working as a member of the health care team. Administered medications and treatments according to physician's orders being aware of the parameters. Understood responsibilities concerning infection control, safety and accident preventions. Completed documentation throughout shift.

Connecticut Juvenile Training School, Middletown, CT

Youth Services Officer

07/04 - 01/06

Performed duties involving care, custody, training, supervision and rehabilitative services of an assigned group of residents. Counseled and advised residents in groups/individually by modeling appropriate behavior. Encouraged residents to establish and develop effective/positive interpersonal relationships. Prepared timely and accurate reports regarding activities, incidents, residence progress and adjustments.

Capitol Region Education Council, East Hartford, CT

Residential Counselor

02/02 - 07/04

Assisted clients to achieve their treatment goals through direct care such as reflecting, teaching and building trust. Maintained detailed logs of client's incidents including compliance with all applicable regulations and reporting procedures. Developed treatment goals for clients through observation of behavioral patterns and special needs of the individual. Implemented an approach that was tailored to meet specific needs of the client which allowed maximum ability to be attained. Acted as house Supervisor for the campus as required.

References furnished upon request

000087

Cynthia Raff Fusco

39 Peach Tree Road
Glastonbury, CT 06033
(860) 633-2539

PROFESSIONAL NURSING SKILLS:

- Experienced at leading adolescent crisis intervention teams
- Proficient at developing treatment and care plans specific to different age groups and diagnoses
- Ability to manage a variety of medications according to current physician recommendations and individual needs

PROFESSIONAL EXPERIENCE:

<p><u>Buttonball Lane Elementary School, Glastonbury, CT</u></p> <p><u>Paraprofessional</u></p> <ul style="list-style-type: none">• On call position at this Blue Ribbon award winning school responsible for assisting students with behavioral and psychological issues	9/2005 – Present
<p><u>Watkinson School, Hartford, CT</u></p> <p><u>Per Diem RN</u></p> <ul style="list-style-type: none">• Called in as needed to provide RN services on overnight field trips and retreats. Responsible for handling behavioral and psychological issues as well as dispensing and monitoring related medications	9/2005 - Present
<p><u>Phoenix Mutual Life Insurance Company, Hartford, CT</u></p> <p><u>Medical Underwriter</u></p> <ul style="list-style-type: none">• Responsible for underwriting the medical on life and disability claims	3/1987 – 12/1987
<p><u>The Institute of Living, Hartford, CT</u></p> <p><u>Head Nurse, Adolescent Psychiatric</u></p> <ul style="list-style-type: none">• Provided professional nursing care through direct patient involvement and through supervision and delegation of responsibilities to staff nurses, licensed practical nurses and psychiatric technicians• Created, evaluated and adjusted standards for a therapeutic environment for patients• Carried 24/7 responsibility for management and nursing care of the unit• Provided in-service education for entire staff• Co-led adolescent psychotherapy group <p><u>Psychiatric Staff Nurse</u></p> <ul style="list-style-type: none">• Team leader responsible and accountable for the quality of nursing care• Supervisor of the Psychiatric Technicians on the unit and their implementation of patient care	10/1985 – 3/1987

Cynthia Raff Fusco

<p><u>Newington Children's Hospital, Newington, CT</u></p> <p><u>Psychiatric Staff Nurse</u></p> <ul style="list-style-type: none"> • Planned and performed supportive, rehabilitative and therapeutic nursing care • Administered medications and treatments • Assisted in planning for patient care according to patient needs and instructed patients and parents as needed in the care of patient upon discharge • Co-led parent support groups and community meetings 	<p>1/1985 – 10/1985</p>
<p><u>Yale Psychiatric Institute, New Haven, CT</u></p> <p><u>Psychiatric Staff Nurse</u></p> <ul style="list-style-type: none"> • Therapeutic counseling and treatment of long-term adolescent psychiatric patients • Management of the unit and staff and delegation of responsibilities to appropriate staff members 	<p>6/1983 – 1/1985</p>

EDUCATION: Rhode Island College Bachelor of Science, Nursing, Cum Laude
 Providence, RI May, 1983

LICENSURE: RN License #E45768 State of Connecticut

PROFESSIONAL TRAINING: *Anxiety...Living and Learning*, Institute of Living
 Leadership Strategies for Psychiatric Nurses, Bridgeport Hospital
 Group Psychotherapy, Mt. Sinai Hospital

REFERENCES: Available upon Request

000059

EVELYN GARNES

OBJECTIVE

To be able to demonstrate my clerical skills and the ability to work in a team environment with strong communication and people skills. Ability to perform multiple tasks while maintaining an attention to detail with the potential of career growth.

EXPERIENCE

2000- Present Otis Elevator Company Farmington, CT

Customer Service Representative

- Handle high volume of calls to mechanics and clients.
- Dispatch calls from Puerto Rico, Bahamas & Canada.
- Program elevator telephones for the American Deaf Association.
- Provide assistance with the Remote Electronic Monitoring System

10/2000-12/2000 Lucent Technologies Avon, CT

Office Clerk

- Filed statements.
- Maintained the switchboard.
- Data input of financial statements.
- Assisted with accounts receivables and account payables.

02/2000-09/2000 Manpower Temporary Agency Enfield, CT

Office Clerk

- Data entry of forms.
- Maintained the switchboard.
- Typed memorandums.
- Faxed documents.

09/1999-01/2000 American Airlines Hartford, CT

Reservationists/Sales

- Provided customer.
- Booked airline reservations.
- Sales/Airline tickets.

1994-1999 Federal Deposit Insurance Corporation East Hartford, CT
Office Assistant

000090

- Assisted paralegals.
- Typed letters, memorandums, and reports.
- Filed legal documents.
- Answered phone calls.

EDUCATION

1994-1998 Bulkeley High School Hartford, CT
▪ H.S. Diploma.

SKILLS

Excel 2002, Word 2002, O/S Windows 98, Typing 60 wpm

Samantha Hruska

P.O. Box 48 Centerbrook, CT 06409

Phone: 860-575-1880 E-mail: H20GRL99@aol.com

Objective:

To obtain a career working with children in an education setting teaching them daily lessons and life long skills.

Qualifications:

Excellent time management and organizational skills
Exceptional athleticism, positive attitude and enthusiastic
Outstanding communication skills

Experience:

Full-time Nanny

Glastonbury, CT

Supervisor: Linda Harrington

*May-August 2005

*Responsibility of two children under the age of 6

Gelston House Restaurant

East Haddam, CT 06423

*June-August 2002-2004

*Waitress, hostess and food runner

*Assisted in training new wait staff

Crystal Lake

Middletown CT

Supervisor: Carla Prince

*June-August 2000-2002

*Life guarded both the community and Crystal Lake Day Camp children

*Taught swim lessons to children ages 5-12

*CPR, WSI and lifeguard certified

Young Horizon's Day Care Center

120 Saybrook Rd.

Higganum, CT 06441

(860) 345-4347

Supervisor: Diana Peterson

*April-August 2002

*Constructed daily activities for the children

*Worked with children 1-10 years of age

000092

Education:

Springfield College, Springfield, MA
Bachelor of Science in Physical Education
Minor in Health Education
May 2006

Related Course Work:

PE Design and Implement K-12
Health Education studies
Motor Development and Learning

Abnormal Psychology
Behavior Modification
Personality Adjustment

000093

Casey Hubelbank
683 Baldwin Avenue
Meriden, CT 06450
(203) 379-0397
e-mail: chayim76@yahoo.com

EDUCATION

*Bachelor of Science
Major in Special Education
Southern Connecticut State University
2000*

*General High School Diploma
Graduated with Honors in Technical Education
New Britain High School
1994*

CERTIFICATION

*State of Connecticut Department of Education
Certification Status: Current Certification Type: Initial Educator
Valid for the period: May 5, 2003-May 4, 2006
Endorsed for:
Comprehensive Special Education grades 1-12 (#265)
Driver Education (035)*

PROFESSIONAL EXPERIENCE

*Special Education Teacher
Connecticut Junior Republic
February 2003 - Present*

Providing academic instruction for adjudicated youth ages 13-17. Involved in implementing behavior program, PPT, as well as staff meetings. Responsible for implementing a history integration program. Make quarterly updates to IEP'S.

00094

Special Education Teacher
Bloomfield Residential Treatment Center, Bloomfield, CT
October 2001 - January 2003

Provided academic instruction for adjudicated male ages 13-17. Involved in creating and implementing behavior modification program, PPT, as well as inter/disciplinary meetings. Responsible for the workplace improvement training program. Designed and implemented new IEP's and made quarterly updates to IEP'S. Responsible for standardized academic testing.

Driver Education Teacher
Phil's Professional Driving School, East Haven, CT
1996 - Present

Serving as an instructor for the driver education training program at the school. Performing a variety of duties including on-the-road and classroom instruction for the public.

Special Education Teacher
Truman Street School, New Haven, CT
September 2000 - June 2001

Responsible for co-teaching a third and fourth grade inclusion and resource classroom. Duties included lesson plans and modifications for the students. Incorporated assorted behavioral implementations for classroom management. Participated on the planning and placement team. Served as the Head Teacher for an Essentials of Literacy classroom program. Worked as a co-teacher, collaborating lesson plans and behavioral modifications for the students.

Traffic Safety Consultant/Traffic Safety Instructor, Gaylord Hospital, Wallingford, CT
1998 - September 2000

Duties included assessing patients who had physical and neurological problems that affected their driving performance. After assessment, made recommendations to enhance patient's performance and involved in the final determination of patient's ability to safely operate a vehicle.

Driver Education Teacher, Sears Driving School, Waterbury, CT
1998 - Present

Served as an instructor, providing classroom and hands on driver's education for the public.

000095

Student Teacher, Sheridan Academy for Excellence, New Haven, CT
October 1999 - December 1999

During the second student teaching experience, provided academic instructions to an eighth grade inclusion/resource class. Other duties included lesson planning and classroom management for the students. Incorporated behavior modifications to improve classroom management. Participated in PPT meetings for the students.

Student Teacher, East Rock Magnet School, New Haven, CT
August 1999 - October 1999

In the first student teaching role, responsibilities included classroom teaching and management for eight severely challenged students. Incorporated sign language and communication boards for students to express their wants and needs using non verbal methods.

VOLUNTEER EXPERIENCE

District Director for New England, Little People of America, Inc.
2003-Present

Little People of America (LPA) assist dwarfs with their physical and development concerns resulting from short stature. By providing medical, environmental, educational, vocational and parental guidance, short-statured individuals and their families can enhance their lives and lifestyles with minimal limitations. Networking by LPA supports national and international growth related and genetic supported groups and enhances knowledge and understanding of short-statured individuals.

Duties include facilitating regional meetings, setting up weekend events, fundraising, referring new families, managing district officers, offering support to district members, attend board meetings at national conferences.

National Teen Coordinator, Little People of America, Inc.
1995 - 1998

Duties included running teen programs and workshops on a national level and creation and production of a teen newsletter, "Teen LPA Today."

Disability Awareness Sensitivity Training, Little People of America, Inc.
1995 - Present

Training program that provides anti-bias workshops to educate the public regarding dwarfism and people with disabilities.

000096

Gregory Hurston
155 Colebrook ST Hartford CT, 06112
(860) 242-5341 & (860) 543-4671
Trelo13@sbcglobal.net

Objective: To obtain a position in the area of Public Health, Health Science and Customer service, utilizing my strong organization and communication skills.

Education: **University of Hartford**, West Hartford CT Sept 2002- Dec.2007
Bachelor of Science, Major in Health Science and a minor in Education
Associate in Arts & Science degree Hillyer College Dec 2004

Work

Experience: **DGS Delta Airlines Agent** May 2006-April 2007

- To assist in a safe and timely arrival and departure of commercial aircraft
- To lead and supervise employees in a fast-paste environment

Town of Windsor, Windsor June 2001- Jan. 2006

Child Care Group-Leader.

- Manage and over-see a highly skilled childcare environment. Organize daily activities and curriculum to facilitate the development of children's physical, mental, and social abilities, and supervise 30- 60 children ages, 4-12, to ensure their safety.

Volunteer

Experience: **AIDS Project Hartford, Hartford, CT** December 2007

- Assist managers in AIDS educational projects in the Hartford community

Geneses Elderly Care, Windsor, CT May 2002- May 2003

Home Health Care Assistant, Sept. 2002- Dec2006

- Provide care to elderly who need help bathing, cooking, cleaning and transportation

Activities Assistant

- Provided one-on-one assistance to patients who needed to be transported to and from activities.

Pedicorp, West Hartford, CT, July 2005- Jan. 2006

- Assist and shadow doctors and nurses in patient visit

Computer Skills:

- Internet researching, Power Point, Excel and Word, CPR and First Aid (adult and child), Therapeutic Crisis Intervention trained.

000097

PERSONAL

Simone, A. Johnson
320 Branford Street
Hartford, CT 06112

040-70-3804
D/O/B May 17, 1965

EDUCATION

Greater Hartford
Community College
61 Woodland Street
Hartford, CT

Took courses in English, Biology, and the Certified Nursing Assistant Course.

Watkinson School
Bloomfield Avenue
Hartford, CT
1979—1980

Hartford High School
1980-1984

EMPLOYMENT

The Hartford Board of Education-Health Division
153 Market Street
Hartford, CT
March, 1995 — Present

The Governors House
36 Fire town Road
Simsbury, CT
September, 1994 — March, 1995

St. Francis Hospital
140 Woodland Street
Hartford, CT
September, 1986 — June, 1993

Cared for medical, surgical, pediatric and maternity, orthopedic, oncology and geriatric patients. Also experienced in caring for people with Acquired Immune Deficiency Syndrome. Responsibilities included pre- and post-operative care, vital signs, range of motion, charting intakes and outputs, patient activities, heights and weights, changing and applying surgical dressings, also experienced inserting urinary catheters.

Quality Care
Nursing Agency
Farmington Avenue

000098

West Hartford, CT
1985 — 1986

Experiences included working in a variety of skilled nursing facilities, patients that were elderly or developmentally disabled, as well as private duty.

References Furnished Upon Request

000099

MARIA S. JACKSON
82 Richard Street
West Hartford, CT 06109
(860) 233-2622

OBJECTIVE: To secure a position utilizing solid business experience with an emphasis on demonstrating commitment to customer service, financial activities, with an opportunity for professional growth.

PROFESSIONAL SKILLS:

Type 50 wpm, Word Perfect, Lotus Ami Pro 3.1, Lotus 1-2-3 Release 5, Word Perfect 5.2+, Microsoft Word, Microsoft Outlook, Excel;
Bilingual (speak and write from Spanish to English with fluency)

EXPERIENCE:

10/02-01/03 **Nutmeg Healthcare Associates, P.C., Hartford, CT.**

Coordinator, Hartford Medical Office

Involved in Patient Relations, appointment scheduling, preparation of professional correspondence, collection of co-pay obtaining medical referrals, and surgical bookings. Provide translation to patients from Spanish to English. Responsible for daily management of office. Supervised medical assistant, receptionist and part-time file clerk.

01/98-10/02 **MassMutual Life Insurance Company, Hartford, CT.**

Sr. Client Service Representative, Annuities New Business Department

Review, assess and complete service request as it relates to policy administration, which may include: risk assessment, determining and obtaining additional information (underwriting, legal, compliance, licensing, and actuarial), and manual calculations (i.e., cash value, premium-dividend, costs, etc.). Work with internal/external customers and agents to: determine requests, advise course of action in accordance with corporate/regulatory requirements while maintaining the client's best interests. Handle premium collection and system balancing functions. Record changes and adjust files to accurately reflect current status and advises appropriate parties.

09/94-12/97 **Sedgwick James of Connecticut, Inc., Hartford, CT.**

Receptionist:

Answer high volume of calls at the switchboard, greet clients, set up conference calls for Sr. Vice President, type memorandums, reports, federal express mailings, correspondence; maintain files, screening mail, parking validations, updating manuals, update daily attendance sheets. Computer input for time-tracking on all accounts. Operate Word Perfect, Lotus Ami Pro 3.1, and Lotus 1-2-3 Release 5.

4/89-08/94 **The Aetna Life & Casualty, Hartford, CT.**

Administrative Assistant for Asst. Vice President, Bond Department

Type memorandums, forms, reports, and correspondence; maintain files, logs, etc. Maintain attendance records and issues them to the Human Resources Division. Provide travel itinerary and visitor's list to the Itinerary/Agenda Coordinator. Provide phone coverage for the whole unit. Make travel arrangements for office personnel and arrange conferences and meetings. Maintain confidential diary system for Assistant Vice President and Director(s), as well as a personal system for collateral draws, pending files, and periodically follow-up with field offices for status on approvals. Prepare documents to liquidate letters of credit and monitor file for receipt of collateral.

EDUCATION:

Present **Capital Community-Technical College, Hartford, CT.**
Concentration in Liberal Arts

9/81-6/85 **Computer Processing Institute, East Hartford, CT.**
Courses Studied: IBM PC, Wang, Typing and Word Processing

9/81-6/85 **New Britain High School, New Britain, CT.**
Studied Business Courses

800100

AKILAH LOPEZ

119 Rood ave • Windsor, CT 06095 • 860-683-4298 Email: Kilah2@excite.com

OBJECTIVE

Seeking a challenging position the Human Services Field. Which will make use of a strong inter-personal skills and organization, and a proven ability to get the job done.

EMPLOYMENT

RESIDENTIAL INSTRUCTOR 2003-CURRENT
The Arc of Farmington Valley *Canton, Connecticut*

- Oversees recreational activities for residents
- Records daily activity in log books
- Escort clients to appointments
- Maintains residents living Quarters
- Management of clients Programs (including management of financial Ledgers)
- Maintaining clients physical and psychological well being

RESIDENTIAL ADVISOR 2001-2002
University of Bridgeport *Bridgeport, Connecticut*

- Program Planner
- Supervise a floor of 35 young ladies
- Counseled students with frustration issues and basic college hindrance
- Maintaining a safe and clean living environment for the young ladies

ADMINISTRATIVE, INTERN 1998-2000
Burgdorff Health Clinic *Hartford,*
Connecticut

- Updated records electronically and manually
- Made appointments for clients and follow ups
- Went out on the field with Nurse and Epidemiologist

EDUCATION

MAJOR: SOCIAL SCIENCE 1997-2002
CONCENTRATION: PSYCHOLOGY *Bridgeport,*
University Of Bridgeport
Connecticut

CERTIFICATIONS

- Medication Certified - 2008
- PART. Certified (equivalent PMT)
- CPR and First Aid Certified - *Did this year*
- HIPPA and OSHA Trained
- Water and Fire safety Trained

000101

Andrew J. Moseley

Permanent Address

45 Hitchcock Way,
South Windsor, CT 06074
Phone (860) 716-2664
Drewroc15@netscape.net

- Objective** To obtain a service position which can provide me with an opportunity for professional growth and real world experience
- Education** 2004 - Present Manchester Community College Manchester, CT
Major: Business Management
- Expected graduation date of December 2007
- Work experience** 09/2004 - Present Foot Locker, Inc. Manchester, CT
Assistant Store Manager / Manager in Training
- Personally responsible for oversight of daily opening and closing of store.
 - Integral part in loss prevention and theft deterrence system for store.
 - Responsible for communicating directly with district manager to discuss matters such as store appearance, sales, and inventory issues
 - Training of new sales associates in all areas, as well as assisting to develop and improve training method.
 - Front line of customer relations, dealing with customer service and responding to customer inquiries.
 - Responsible for research and replenishment, as well as oversight of annual inventory count.
 - Daily supervision of the store, including staff, inventory, and performing duties as acting manager in their absence.
- 06/2003 – 08/2004 Manchester Moving and Storage Manchester, CT
Team Leader
- Headed team of movers assigned to multiple jobs.
 - Dealt directly with customers during each move, and handled decisions not requiring store owner approval.
 - Responsible for driving truck and maintaining safe work environment at all times.
- Activities & Interests**
- Organized and established men's recreational basketball league.
 - Strong desire for continuing education.
 - Varsity letter in track and field, and soccer for S. Windsor High School.
 - Active member of Wapping Community Church
 - References available upon request.

000102

Delores D. McNeil

206 Collins St., 4-D, Hartford, CT 06105

Home (860) 548-1984

OBJECTIVE

To obtain a position with a growth oriented company that will utilize my skills and abilities, while providing learning experiences and career growth opportunities.

HIGHLIGHTS OF QUALIFICATIONS

- Process office skills such as data entry-alpha/numeric in a fast pace setting . excellent customer service skills, mail opening machine.

EMPLOYMENT HISTORY

Fleet Libris Information Solutions • Windsor, CT • 2003 to Present

Operation Associate I

Responsible for opening and sorting various type of tax forms and payments then preparing work for the processing department.

Village for family and children • [Hartford, CT] • 2001 to 2002

prep chef

meal preparation, preparation for catering, parties and special events.

Pierce Pharmacy • [Hartford, CT] • 1997 to 2001

Cashier/Pharmacy Tech.

Assisting Pharmasist in filling perscriptions, assisting customers in wire transfers, faxing and general cashering.

State Of Connecticut Dept. of Revenue services • [Hartford, CT] • 1997 to 1999

Tax Clerk

Reconciled incoming taxes, reviewed taxes for accuracy, opened mail and encoded checks for ncr operations.

Fleet Services Corp. • [East Hartford, CT] • 1994 to 1997

Operations Clerk

Verify mortgage payments, make credit/debt entries for incorrect items, balance to the general ledger and make deposit slips.

EDUCATION

Hartford public high school • Hartford/CT • 1983

H.S. Diploma

000103

Paul J. Mullen, M.A., C.A.G.S.
34 Brian Road
West Hartford, CT 06110
Telephone: 860-232-7914
Cell Phone: 860-604-5062
E-mail: pjmulen@sbcglobal.net

Objective: As a retired educator, it is my goal to continue to work part time in public schools in Connecticut primarily on behalf of students with disabilities.

Administrative Career Experiences

- 08/94 – 06/01 Director of Special Education Programs
EASTCONN, Hampton, CT
- 07/92 – 06/94 Supervisor of Special Education
Berlin, CT
- 11/90 – 06/92 Educational Consultant
Connecticut State Department of Education
Bureau of Special Education and Pupil Personnel Services
Middletown, CT
- 10/91 – 01/92 Consultant
Special Education Resource Center (SERC)
Middletown, CT
- 06/90 – 11/90 Assistant Principal
Pulaski Middle School
New Britain, CT
- 09/89 – 06/90 Assistant District Coordinator of Special Education
New Britain, CT
- 07/86 – 09/89 Supervisor of Special Education
Plainville, CT
- 09/78 – 06/79 Principal (Acting)
E. E. Trask Elementary School
Plainville, CT

Career Teaching Experience

- 09/84 – 06/86 Wheeler School, Plainville, CT
Intermediate self-contained special education class
- 09/79 – 06/84 Wheeler School, Plainville, CT
5th grade general education class
- 09/76 – 06/78 E.E. Trask Elementary School, Plainville, CT
Special Education Resource Room for grades K-6
- 09/70 – 06/76 Linden Street School, Plainville, CT
3rd grade general education class

000104

09/66 – 06/67 St. Augustine School, Hartford, CT
6th grade general education class

Recent Consultative and Part Time Experiences

1/03 – 6/03 Education Director
Odyssey Community School
Manchester, CT

7/02 – 11/02 Interim Director of Special Education
Sprague Public Schools, Baltic, CT

8/15/01-6/30/02 Interim Director of Special Education Programs
CT Department of Mental Health and Addiction Services
Hartford, CT

7/1/02-11/25/02 Interim Director of Special Education
Sprague Board of Education
Scotland Road
Baltic, CT 06330

11/1/03-5/26/04 Interim Director of Special Education
Ashford Board of Education
440 Westford Road
Ashford, CT 06278-1113

Ongoing Consultant to Marlborough Elementary School for Special Education
Marlborough Elementary School
25 School Drive
Marlborough, CT 06447

Education

1979-1980 University of Connecticut
Educational Administration Certification Program

1975-1978 St. Joseph College
Sixth Year Certificate in Special Education

1969-1973 Central Connecticut State University
Master of Science – Teacher Certification, Elementary Education

1962-1966 Providence College
Bachelor of Arts – Sociology

Certification

State of Connecticut Certificate 043-34-2079

- ❖ Pre-Kindergarten Through Grade 8 (001)
- ❖ Comprehensive Special Education, Grades Pre-K – 12 (065)
- ❖ Intermediate Administrator and Supervisor (092)

000105

CHARLOTT PORTER

136 Main Street Unit B1
Hartford, CT 06106

(860) 656-5900
charlottporter@yahoo.com

SUMMARY OF QUALIFICATIONS

Ambitious professional with strong management, administrative and social service skills. Ability to foster relationships, develop credibility, establish trust and rapport with clients. Excels at providing supportive and detailed services in community and quality of life development through effective communication, leadership, community service and teamwork.

EDUCATION

SAINT JOSEPH COLLEGE

Bachelor of Science, Business Management

- Focus in Organizational Management
-

MY SISTERS' PLACE

SUPPORTED RECOVERY HOUSING PROGRAM HARTFORD, CT

DECEMBER 2009- PRESENT (PART-TIME)

Case Manager

- Provide ongoing support and expertise through comprehensive assessment, planning, implementation and overall evaluation of individual patient needs.
 - Apply for housing/entitlements for clients in a timely manner in order to meet their needs
 - Ensure that clients maintain sobriety by mandating daily meetings/self help groups
 - Assists clients with meeting goals to achieve and maintain independent housing
 - Coordinates the integration of social services/case management functions into the patient care, discharge, and home planning processes
 - Promote effective and efficient utilization of clinical resources
 - Conducts review for appropriate utilization of services from admission through discharge through GPRA
-

GRAY LODGE SCHOOL AND RESIDENTIAL FACILITY, HARTFORD, CT

MAY 2006 – MAY 2010 (Program Closing)

Residential Supervisor

- Facilitate a performance management process for employees ahead of plan, that included monthly supervision, yearly evaluation, and corrective discipline
- Ensure that training requirements of new employees are achieved within probation period in order to perform daily tasks.
- Review completion and maintenance of records and reports regarding residents' histories and progress, services provided, and other required information
- Evaluate the work of staff to ensure that programs and services to residents are of appropriate quality and that resources are used effectively
- Participate in the determination of organization policies regarding such issues as participant eligibility, program requirements, and program benefits
- Establish and oversee administrative procedures to meet objectives set by senior management
- Maintain balanced accounts and experience with implementing budget with 100% accuracy each week based on the activities of the organization
- Maintain professional communication both verbal and written within internal and external team members to assure a productive, and informed work environment

000106

COLUMBUS HOUSE, WATERBURY, CT
JANUARY 2005 – DECEMBER 2009 (Part-time)
Case Manager

- Assisted women in domestic violence situation to transition into independent safe environment
- Developed specific and achievable goals based on needed areas identified in assessment.
- Developed measurable objectives tailored to clients unique situation
- Provided recourses including educational and medical services
- Maintained professional communication both verbal and written within internal and external team members to assure a productive, and informed work environment

GRAY LODGE SCHOOL AND RESIDENTIAL FACILITY, HARTFORD, CT
MAY 2003 – MAY 2006

Student Support Coordinator

- Completed and maintained accurate records and reports regarding the clients' histories and progress, services provided, and other required information
- Counseled clients, individually and in group sessions, to assist in overcoming dependencies, adjusting to life, and making changes
- Participated in the development of client treatment plans
- Reviewed and evaluated clients' progress in relation to measurable goals described in treatment and care plans
- Intervened as advocate for clients to resolve emergency problems in crisis situations
- Attended training sessions to increase knowledge and skills

SECRETARY OF STATE, HARTFORD CT
BUSINESS DEVELOPMENT AND COMMUNITY OUTREACH
SEPTEMBER 2004 - DECEMBER 2004

Intern

- Assisted the Director of Business Development and Community Outreach in updating the website and the quarterly newsletter
- Attended charitable events and assisted with ticket sales and registration
- Created worksheets of small businesses in and around the Hartford Area
- Prepared packages with marketing tools of the upcoming showcase and mailed to potential exhibitors with small businesses

CERTIFICATIONS

Endorsement A Driver's License, Seminar Training- How to Supervise, IRS Tax Preparation, CBIA Annual Supervisor's Conference 2008 - (On-Boarding new Hires, Annual Performance Review, Employment Laws, Managing Emotional Intelligence, Team Play and Employee Conflict)

DATABASE KNOWLEDGE

Proficient knowledge of Microsoft Word, Excel, PowerPoint, Access, FrontPage, Outlook, EZ Labor Management System

000107

Sheboan Marie Rivera

81 Montowese Street, Hartford, CT 06114
(860) 461-3313 sheboan@gmail.com

Excellent interpersonal skills, committed to accomplishing goals, seeking a career in the field of psychology to work with children and adolescents in a clinical or school setting. Experience in working with elementary and high school students and their families, has prompted me to set developing affordable counseling programs for inner-city families, as my long term goal.

Education:

High School Diploma from Conard High School in West Hartford, CT- 1998
Bachelor's Degree in Psychology from Central Connecticut State University- 2007

Related Experience:

2007- Conducted research project at Smalley Academy in New Britain, on gender behavior between boys and girls in the second grade. Assisted professor in independent research study, and help develop survey for study.

2006- Interned in Family Resource Center and in classroom at Smalley Academy. Assisted teachers and worked directly with students in math and Spanish. Attended play group of children from birth to 5 years old; set up play areas and supervised play time.

Work Experience:

2003 to present CVS Pharmacy, West Hartford and Boston
Photo Technical supervisor and cashier- Responsible for processing 20 rolls a film a day, monitoring photo machines' performance and working with computer technician when they break down, training new photo technicians in developing film and to operate the machines, and assisting customers in utilizing auto processing photo machine

2003-2004 Cardinal Cushing Center, Boston, Massachusetts
Night school front desk secretary- Attended front desk phone calls, was responsible for making daily data entries into the student attendance record, sorted mail, and assisted teachers and school director with filing and making copies

Additional Qualifications:

Fluent in English and able to communicate in Spanish
Computer literate: master word processing, power point and Excell
Fall of 2008 candidate for Masters Degree Program in psychology at Central Connecticut State University

000108

Sandra Rodríguez

90 Catherine Street Apt. A-3 Hartford, CT (860) 293-3985 (W)

- **profile**

Professional, bilingual individual with a serious sense of responsibility and strong commitment to getting the job done.

- **experience**

3/99 – present

Community Partners in Action/Beyond Fear program **Hartford, CT**
ADMINISTRATIVE ASSISTANT: Responsible for all office tasks of this HIV/AIDS awareness education program, sponsored by Community Partners in Action, a non-profit agency. Preparing and submitting quarterly, and year end reports to the Department of Public Health. Prepare and translate to Spanish Beyond Fear program quarterly newsletter. Processing program contractors invoices for payment. Preparing and maintaining databases with regular data entry. Ordering and inventory of supplies. Daily word processing, faxing, mailing, filing.

9/95 – 10-97

Benova, Inc. **Farmington, CT**
RECEPTIONIST: Answered phones and transferred them accordingly. Greeted and directed visitors. Prepared Automatic Call Distribution reports with daily phone call activities. Supplies inventory. Translated to Spanish Medicaid Managed Care correspondence and medical coverage information for the Spanish speaking Medicaid population. Prepared presentations using PowerPoint for Executive Manager. Prepared complex budgets and faxing. Supported management staff with computer application knowledge and general office administration duties.

8/94 – 11/94

City of Hartford, Department of Social Services **Hartford, CT**
SENIOR CLERK TYPIST: Answered phones, light typing, supplies inventory. Prepared client files submitting them to the Department of Social Services, City of Hartford, Main Intake office. General office administration.

- **awards**

Benova, Inc., CT

Employee of the Month – 8/96

Morse School of Business

Student of the Month – 6/94

Skills: Windows 95 Microsoft Suite, 55WPM, English/Spanish, Excellent customer service and phone skills

000109

DARRYL RICH

MMW
12/2
30

SUMMARY OF QUALIFICATIONS

Through my past experience interning in group homes and prevention programs it has enabled me to acquire and demonstrate an abundance of knowledge and skills. From this learning experience I have acquired a knowledge base to be used in understanding the person-in-environment configuration that deals with multi-level systems impacts (individual, group, community). I have developed the discipline use of self as a professional. I am able to identify one's strengths and weaknesses as well as my own. I was also able to develop relationship skills that are pertinent to the helping process. These components include being empathetic, accepting, non-judgmental, confidentiality, trusting and self determined. I am able to identify and engage in a general set of problem solving activities. Furthermore, my work experience has been a stepping stone for me to strive to foster my highest potential and to contribute to an organizational climate which sustains everyone's active participation and positive contribution.

EDUCATION

1997 - 2002 Norfolk State University Norfolk, VA
Bachelor of Social Work (BSW) May, 2002
Major: Social Work

EMPLOYMENT

2001 - 2001 Stanhope Group Home Norfolk, VA
Intern

- Intake process
- Formal counseling sessions
- Organized activities for residents
- Helped residents with homework
- Recorded information for log entries
- Overall supervision of residents

000110

2001-2001 United Technologies Shared Services Windsor, CT

Temp

- Data entry
- Filing data
- Scanning invoices

2001-2001 Allaso Evening Reporting Center Norfolk, VA

Intern

- Home visits
- Formal counseling sessions
- Participated in Allaso staffing
- Facilitated daily structured groups
- Supervised participants on outings

REFERENCES

Available upon request

OBJECTIVE

To secure a position as a counselor or mentor working with children, teens or young adults where a special ability to motivate and communicate effectively is needed.

VOLUNTEER EXPERIENCE

Counseled youth at ALLASO Evening Reporting Center designed to work with youth in need of improving social skills, peer relations, dealing with authority and improving in impulse control.

000111

Suzanne A. Sharp
8 Autumn Drive Enfield, CT 06082

Telephone: 860.741.0454
Cell: 860.670.4437
E-Mail: suz0430@aol.com

Education

Central Connecticut State University - New Britain, CT

B.S.E.D., May, 2003 – Magna Cum Laude
Dean's List
Concentration in English
M.S.E.D. Special Education, May, 2005 – Summa Cum Laude

Experience

Sinai School, St. Francis Care - Hartford

Clinical Educator II
Responsibilities: Assessment, Modification, and Implementation of curriculum and behavior plan of students admitted in the hospital for psychiatric treatment. Entails contact with teachers and psychologists of the student's home school as well as collaboration with Psychiatrist, clinician and nursing staff at the hospital. Assign grades and end of stay analysis of performance for student report cards.
August, 2004 - Present

Long-term Substitute: Fifth grade - Somers, CT

Responsibilities: Teaching Health and Science to two classrooms and all other subjects except Social Studies to one class.
Curriculum Development and collaboration with four other fifth grade teachers. Attend PPTs. Collaborate with the Special Education Teacher for three students. Hold Parent-Teacher conferences. Prepare students for school change to middle school. Assign grades and end of year analysis of performance for student report cards.
December, 2003 – May, 2004

Long-term Substitute: Special Education - Enfield, CT

Responsibilities: Assessment, Modification, and Implementation of curriculum and behavior plan of students. Case load of nine students.
Co-teach in Inclusion settings. Attend PPT's. Assign analysis and grades on student report cards.
October, 2003 – December, 2003

000112

Skills

Quick Assessment Ability

Background in Reading Recovery

Background in Technology

Trained in NCI and LSCI

CPR Certified

Activities and Honors

President of Kappa Delta Pi Honor Society

Member of Golden Key Honor Society

Magna Cum Laude, 2003

Summa Cum Laude, 2005

000113

Rohan Thompson
49 Woodmere Road
West Hartford, CT. 06119
(860) 904-9231

Work Experience

- May 2007-Present Klingberg Family Centers. Responsibilities: Aid and assist children with mental health and behavioral problems.
- January 2004-August 2008 Boys and Girls Clubs of Hartford at Northwest. Title: Athletic Director. Create, coordinate and supervise physical education programs for children age six to eighteen. Oversee other club activities and programs. Create and Coordinate physical education programs in neighboring schools.
- August 2003-January 2004 Boys and Girls Clubs of Hartford at Southwest. Title: Unit Director. Supervise all staff, areas of the club as well as activities. Coordinate educational and physical education in neighboring schools. Market Boys and Girls Club Programs; create and supervise fundraisers
- Nov. 2000-August 2003 Boys and Girls Clubs of Hartford at Trinity College. Title: Athletic Director. Create, coordinate and supervise physical education programs for children age six to eighteen. Oversee other club activities and programs. Create and Coordinate physical education programs in neighboring schools.
-
- August 1998-May 1999 Office of Professional Development, ECSU, Willimantic, CT. Title: Student Worker. Provide information for non-matriculated students who were interested in taking computer classes at our facilities. Took information given about the students and reverted this information to database.
- May 1997-August 1998 Office of Professional Development, ECSU, Willimantic, CT. Title: Summer Camp Assistant. Provide children and adults that were using the facilities for the summer with supplies needed for their camp. Conducted safety inspections.

000114

August 1997-May 1998

Advisement Center, ECSU, Willimantic, CT. Title: Peer Advisor Internship. Met with seven students once a week to go over their weekly progress. Provided help in areas that students needed. Proofread and corrected papers. Helped students choose necessary classes for the upcoming semester.

June 1995-May 1998

Camp Horizons, South Windham, CT. Title: Camp Counselor. Assist mentally and physically challenged children and adults with their daily activities such as chores, showers and meals. I also coordinated and assisted in activities for the campers. There was three months of summer camp and during the winter, fall and spring months the camp would operate on the weekends only.

Training

December 2000

Child Safety

February 2001

Smart Girls/Smart Moves

April 2001

Diversity Training

June 2001

Program Basics

October 2001

Programming for Girls

Currently

Public Service License

Currently

TCI Training

Currently

CPR Training

Education

Eastern Connecticut State University, Willimantic, CT.

113.5 (of 120) credits towards a Bachelor of General studies and minor in sociology

References

References will be furnished upon request.

000115

Marcus D. Tappin
36 Olmsted Street, East Hartford, CT, 06108
(860) 461-6352(home) or (860) 209-4430(cell)

OBJECTIVE

My intention is to work at the Village as a Child Development Specialist in a position that offers growth, satisfaction and opportunities for advancement.

EDUCATION

Howell Cheney Tech. School
791 West Middle Turnpike, Manchester CT. 06040
Basic studies/ Automotive Dept.
Gateway Tech. College
New Haven, CT
Toyota T10 Program

EMPLOYMENT

East Hartford Board of Education/ Synergy Alternative High School
February 1999- Present/ January 2002-Present
Behavior Manager/Tutor, Transitional Education program

Provide classroom management assistance.
Implement behavior modification plans.
Provide treatment plans for student's ages 5 to 18 classified/
diagnosed with emotional, social or behavior maladjustment.
To ensure safety of all students and staff.
Provide transportation supervision.

Connecticut Pride Basketball Summer Camp
Summer of 1994-Summer of 1997

Coached basketball teams ages 6 to 16-years.
Provided supervision and positive interaction with young children
in variety of situations.
Showed and taught children the skills they needed to enhance their
skills in basketball.
Ensured safe and enjoyable basketball supervision for all children.

Dan's Auto Sales, Repairs and Service
March 1999-February 2000

Repaired and serviced customers' car.
Dealt with customers' complaints and diagnosed customer
problems.
Detailed cars and prepared them for sale.
Wrote out customers' bills and made appointments over the phone.

000116

Resurrection Life Christian Center Church International
November 1992-Present

Prepare Sunday school lessons for children.
Help young children to understand the Bible.
Help church staff setup church equipment.

SKILLS

Adult CPR
Crisis Intervention Training
Quick learner who can easily adapt to new responsibilities.
Work well with others.
Great organization and communication skills.

References Available Upon Request

000117

Yvette Young

1 Broadview Place
Windsor, CT 06095
(860) 803-5894
autum_sunshine@hotmail.com

EDUCATION

Cambridge College: Springfield, MA
Master of Education, Licensed Mental Health Counseling, June 2002
(License Eligible)

Trinity College: Hartford, CT
Bachelor of Science in Psychology, May 1998
Interdisciplinary Minor: Performance Art

University of East Anglia: Norwich, England, January-June 1997

CERTIFICATION

CT Sexual Assault Crisis Intervention Counselor

WORK EXPERIENCE:

YWCA of the Hartford Region, Inc. Hartford, CT **July 2005 – November 2005**
Consultant: Rendered independent consultation services to the YWCA. Responsibilities included development, planning, coordination, and implementation of all events for the organization's annual Week Without Violence. Identified collaborators, speakers and participants. Implemented divergent outreach activities in the greater Hartford region to promote activities, recruit, and align community-based speakers and participants; establishing collaborative partnerships. Responsible for the evaluation and review of all early learning centers, before/after school programs and youth development programs. Identified and developed enhancement opportunities for all programs. Conducted extensive volumes of two-way communication, via interviews, e-mail correspondence, and phone contact to ensure the integrity and quality of program evaluations, and reporting data.

YWCA of the Hartford Region, Inc. Hartford, CT **September 2004 – July 2005**
Sexual Assault Crisis Service Program Director: Responsibilities included the development and evaluation of sexual assault services. Ensuring that the sexual assault program and services are complying with federal, state and departmental mandates. Identifying, developing and implementing new program initiatives and services. Identifying, developing, monitoring and achieving funding sources, departmental budget goals and outcome measures. Developing, assessing and evaluating departmental policies and procedures. Establishing, maintaining and adhering to organizational and departmental procedures. Collecting of and analyzing monthly and quarterly statistical data. Conduct and evaluate 4 staff members performance. Establish and determine the departments, staff and volunteers priorities, workload and hours. Overseeing and maintaining confidential records. Provide training, education and outreach to 31 towns in the Greater Hartford and Tolland counties regarding sexual assault. Provide counseling and advocacy to a small caseload of 5 - 10 clients. Preparation of various reports. Provide direction and supervision to 4 staff members, 4 interns and over 100 volunteers. Conduct high volumes of two-way communication in person and via phone.

Catholic Charities/Catholic Family Services: Hartford, CT **October 2002- September 2004**
Social Worker: Provide mental health counseling services to clients in an outpatient treatment facility. Provide quality casework services to families, couples, children and adults. Provide advocacy services to clients. Develop and implement client treatment plan. Assess and provide diagnostic information on individual clients. Maintain client records. Develop and facilitate psychoeducational/support groups.

000118

Provide administrative/clinical supervision to interns. Manage department's case assignment system. Responsible for Intake/Social Worker of the day duties on a monthly basis. Functioned as the program manager on an interim basis. Responsibilities included supervision of a full time social worker and a second year graduate intern as well as general oversight of the program.

YWCA Sexual Assault Crisis Service: Hartford, CT **September 2001-September 2002**
SACS Coordinator: Functioned as the Training Coordinator. Responsible for the supervision and training of Interns within the program. Oversee and manage the day to day operations of the department as well as the direct supervision of 5 staff members and 80 volunteers indirectly in Director's absence. Responsible for coordinating all community education services provided by the department.

YWCA Sexual Assault Crisis Service: Hartford, CT **May 1998-September 2002**
Training Coordinator: Responsible for planning, developing, coordinating, and implementing SACS volunteer training two times per year certifying a minimum of 65 new volunteers annually who will staff SACS 24 hour hotline. Train, supervise and evaluate SACS training small group facilitators. Recruit competent and responsible individuals from the community able to provide volunteer services to SACS. This requires developing and maintaining contacts with the media, community agencies, volunteers and others who can ensure an adequately staffed 24-hour hotline. Interview all interested volunteers. Plan, develop and implement two inservice training per year for staff and volunteers. Serve as the staff liaison for the Volunteer Advisory Committee. Create and distribute Bi-monthly newsletter. Developed curriculums and implemented Community Education and Face to Face Counseling Training for volunteers. Develop curriculums for various community education presentations. Conduct community education presentations for professional groups, High Schools, Police Officers, Colleges, and various community organizations. Provide direct service counseling via hotline or in person to primary and secondary victims of sexual violence. Provide crisis intervention counseling, short-term counseling, and advocacy support within the medical, legal, and police system. Work on monthly statistical reports. Conduct high volumes of two-way communication in person and via phone.

COMMITTEES AND ELECTED POSITIONS

Woman of Color Caucus against Sexual Assault (WOCCASA): This organization is geared towards increasing the representation of women of color within the sexual assault movement. We also focus on increasing culturally competent services to victims of sexual assault.

President: December 1998- July 2000

CONNSACS Board Liason: July 2000 – June 2003

Member: December 1998 – July 2005

YWCA of the Hartford Region

Board of Directors: Member, January 2003 – September 2004

Soromundi Housing Inc.

Board of Directors: Treasurer/Secretary, September 2003 - Present

COMPUTER SKILLS:

Knowledge of PC software. Especially Microsoft Word, Access, Outlook, Publisher, Excel, and Internet.

000119

Nancy Gonzalez

51 Jensen Street • Manchester, CT, 06042. • 860-652-5370
gonzalez708@juno.com

QUALIFICATIONS

- Currently licensed as a Registered Nurse in CT
- Perform patient assessments
- Proficient in medication administration
- Ability to independently prioritize, organize and achieve set goals
- Adept at building and maintaining effective working relationships
- Experience with medically fragile patients
- Enthusiastic and self-motivated, adapting easily with a positive attitude to new protocols and changing environments.
- Extremely organized with proficiency in charting and documentation, attention to detail.

PROFESSIONAL EXPERIENCE

The Village for Families and Children, Hartford, CT <i>Pediatric Psychiatric Nurse – Sub- Acute Unit</i>	12/09- Present
St. Francis Hospital, Hartford, CT <i>Registered Nurse/Cardiac Step-Down / Telemetry Unit</i>	07/09- 12/09
Pratt & Whitney, East Hartford, CT <i>Administrative Assistant</i>	08/06 – 06/09
Capra Asset Management, Rye NY <i>Administrative Assistant</i>	10/00 – 03/04
UST Incorporated, Greenwich CT <i>Employee Benefits Coordinator</i>	09/98 – 08/00

EDUCATION

Goodwin College East Hartford, Connecticut	09/05 – 5/09
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Associate of Science In Nursing

LICENSES AND CERTIFICATIONS

Registered Nurse Licensure
State Of Connecticut
License # 088920

American Heart Association
Healthcare Provider BLS CPR and AED Certified

LANGUAGE SKILLS

Able to read, write and speak Spanish

000120

ZOEY WALKER

8 Napoleon Drive
Broad Brook, CT 06016

(860) 8308031
laxoi@yahoo.com

SUMMARY OF QUALIFICATIONS

Ambitious professional with strong healthcare and social service skills. Ability to foster relationships, develop credibility, establish trust and rapport with clients.

EDUCATION

EC GOODWIN TECHNICAL COLLEGE

Licensed Practical Nurse

THE VILLAGE FOR FAMILIES AND CHILDREN

SUBACUTE RESIDENTIAL PROGRAM

JULY 2007- PRESENT

Child Development Specialist

- Counsel clients, individually and in group sessions, to assist in overcoming dependencies, adjusting to life, and making changes
- Participate in the development of client treatment plans
- Reviewed and evaluated clients' progress in relation to measurable goals described in treatment and care plans
- Intervene as advocate for clients to resolve emergency problems in crisis situations
- Attend training sessions to increase knowledge and skills

HARTFORD BOARD OF EDUCATION

SEPTEMBER 2007- PRESENT

Special Ed Nurse

- Prepare and administer medication on a daily basis
- Taking vital signs of clients
- Perform catheterizations
- Monitoring patients and reporting changes
- Collecting samples for testing
- Monitoring food and liquid input/output

CERTIFICATIONS

Endorsement V (PSL) Driver's License, Licensed Practical Nurse (LPN), CPR (First Aid/ AED), Therapeutic Crisis Intervention Trainer (TCI), Sexual Harassment Prevention,

DATABASE KNOWLEDGE

Proficient knowledge of Microsoft Word, Excel, PowerPoint, Access, FrontPage, Outlook, ADP, EZ Labor Management System

000121

APPENDIX E
Non-profit Status Letter

000122



Department of the Treasury
Internal Revenue Service

P.O. Box 2508
Cincinnati OH 45201

In reply refer to: 0248364798
Dec. 03, 2008 LTR 4168C E0
06-0668594 000000 00 000
00019913
BODC: TE

VILLAGE FOR FAMILIES & CHILDREN INC
1680 ALBANY AVE
HARTFORD CT 06105-1001808



21798

Employer Identification Number: 06-0668594
Person to Contact: Mr. Bayer
Toll Free Telephone Number: 1-877-829-5500

Dear Taxpayer:

This is in response to your request of Nov. 21, 2008, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in April 1953, that recognized you as exempt from Federal income tax, and discloses that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section(s) 509(a)(1) and 170(b)(1)(A)(vi).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely yours,

Michele M. Sullivan

Michele M. Sullivan, Oper. Mgr.
Accounts Management Operations I

000123

APPENDIX F
DCF/DPH Licenses

000124



DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities



Susan I. Hamilton, M.S.W., J.D.
Commissioner

M. Jodi Rell
Governor

December 20, 2010

Gallo A. Rodriguez, Executive Director
Village for Families and Children
1680 Albany Avenue
Hartford, CT 06105

Re: CCF/RT -44

Dear Mr. Rodriguez,

On November 16th we received your agency's plan of correction. The plan submitted by you addresses the fifteen areas of non-compliance identified in the inspection report. This inspection included the Regulations for Operation of Child-Caring Agencies and Facilities 17a-145-48 through 17a-145-98, the Psychiatric Residential Treatment Facilities Guidelines and the DCF Guidelines for the Administration of Medication by Certified Staff. The Department accepts the plan of correction and has determined that your agency has met the requirements for a regular license. This license is effective as of August 1, 2010 and is valid for twenty-four months. We thank you and your staff for your cooperative participation in the review process.

Any comments, concerns or questions you have regarding these findings should be addressed to this Department.

Sincerely,

Patrick Hughes
Regulatory Consultant
Department of Children and Families
505 Hudson Street
Hartford, CT 06106
(p) 860-550-6552
(f) 860-550-6665
patrick.hughes@ct.gov

000125

STATE OF CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that in accordance with the provisions of Sections 17a-145 and 17a-151 of the General Statutes of the State of Connecticut, as amended, The Village for Families and Children, INC., located at 1680 Albany Avenue, in the Town of Hartford is hereby licensed as a CHILD CARE FACILITY to provide RESIDENTIAL TREATMENT services to children at the locations listed below for the licensed bed capacity (LBC) and gender listed beside each location.

This license is issued effective August 1, 2010 for a period of TWENTY-FOUR MONTHS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

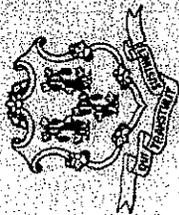
Signed at Hartford, CT the 21st day of December 2010.

License No. CCF/RT-44

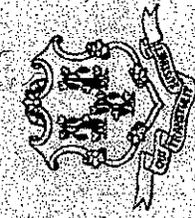
James McPherson
James McPherson, Program Supervisor
Office of Legal Affairs

* Eagle House 1680 Albany Ave. Hartford, LBC: (Males/Females Ages 6-12)

000126



State of Connecticut



Department of Public Health

In Accordance with Connecticut General Statutes 19a-77 to 19a-87 inclusive,
the Department of Public Health issues this license, which is non-transferable, to:

VILLAGE FOR FAMILIES AND CHILDREN, INC.
1680 ALBANY AVENUE
HARTFORD, CT 06105

to operate a

CHILD DAY CARE CENTER

at

VILLAGE CHILD DEVELOPMENT CENTER
1680 ALBANY AVENUE
HARTFORD, CT 06105

License Number: 16592

Expiration Date: 10/10/2012

Approved for the Following Services:

*Preschool *

Maximum Children at One Time: 20

Children Under 3 Years of Age : 0

410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134-0308
Telephone: 1-800-282-6063

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H., Commissioner

000127

STATE OF CONNECTICUT

Department of Public Health

License No. 0418

**Facility for the Care or Treatment of Substance
Abusive or Dependent Persons**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Village for Families & Children, Inc. of Hartford, CT, d/b/a Village for Families & Children, Inc. is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Village for Families & Children, Inc. is located at 105 Spring St, Hartford, CT 06105 with:

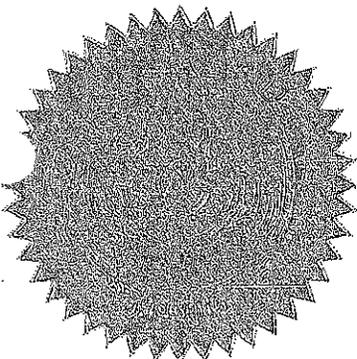
Galo Rodriguez as Executive Director

The service classification(s) and if applicable, the residential capacities are as follows:

Outpatient Treatment

This license expires **March 31, 2013** and may be revoked for cause at any time.

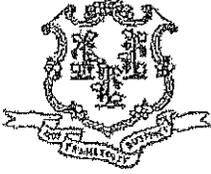
Dated at Hartford, Connecticut, April 7, 2011. INITIAL.



Jewel Mullen MD

Jewel Mullen, MD, MPH, MPA
Commissioner

000128



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Galo Rodriguez, Executive Director
Village for Families & Children
1680 Albany Ave
Hartford, CT 06105

FROM: Sandra C. Bauer, Licensing Examination Assistant

DATE: April 8, 2011

Enclosed is your license to operate a **Facility for the Care or Treatment of Substance Abusive Persons.**

The license must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Division of Health Systems Regulation must be notified immediately if you:

1. Change the Executive Director.
2. Plan any structural changes.
3. Plan to move.
4. Plan to sell the facility.
5. Plan to discontinue operation.
6. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

If I can be of any assistance, please do not hesitate to contact me.

Enclosure(s)



Phone: (860) 509-8023 Fax: (860) 509-7538
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12FLIS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

000129

STATE OF CONNECTICUT

Department of Public Health

License No. 0285

**Facility for the Care or Treatment of Substance
Abusive or Dependent Persons**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Village for Families & Children, Inc. of Hartford, CT, d/b/a Village for Families & Children, Inc. is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Village for Families & Children, Inc. is located at 331 Wethersfield Avenue, Hartford, CT 06114 with:

Galo Rodriguez as Executive Director

The maximum number of beds shall not exceed at any time:

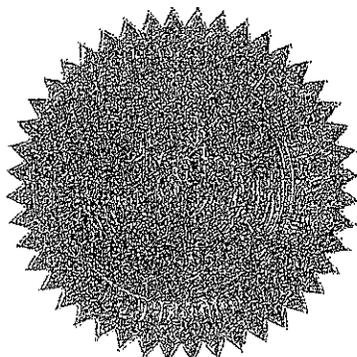
0

The service classification(s) and if applicable, the residential capacities are as follows:

Outpatient Treatment

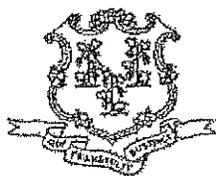
This license expires **March 31, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2011. RENEWAL.



Jewel Mullen
Jewel Mullen, MD, MPH, MPA
Commissioner

000130



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Laurie Valentine, LCSW, Director of Compliance & Privacy
The Village for Families & Children
1680 Albany Ave
Hartford, CT 06105

FROM: Sandra C. Bauer, Licensing Examination Assistant

DATE: March 14, 2011

Enclosed is your license to operate a **Facility for the Care or Treatment of Substance Abusive Persons.**

The license must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Division of Health Systems Regulation must be notified immediately if you:

1. Change the Executive Director.
2. Plan any structural changes.
3. Plan to move.
4. Plan to sell the facility.
5. Plan to discontinue operation.
6. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

If I can be of any assistance, please do not hesitate to contact me.

Enclosure(s)



Phone: (860) 509-8023 Fax: (860) 509-7538
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12FLIS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

000131

STATE OF CONNECTICUT
Department of Public Health

License No. SA-0218

Facility for the Care or Treatment of Substance
Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Village for Families & Children, Inc. of Hartford, CT, d/b/a Village for Families & Children, Inc. is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Village for Families & Children, Inc. is located at 1680 Albany Avenue, Hartford, CT 06105 with:

Galo Rodriguez as Executive Director

The maximum number of beds shall not exceed at any time:

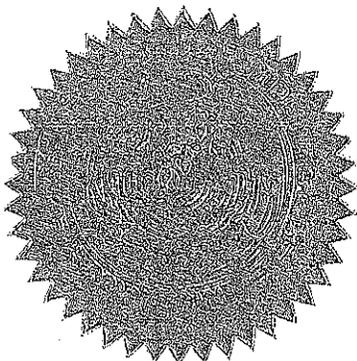
0

The service classification(s) and if applicable, the residential capacities are as follows:

Outpatient Treatment

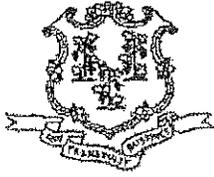
This license expires **September 30, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. RENEWAL.



Jewel Mullen
Jewel Mullen, MD, MPH, MPA
Commissioner

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Galo Rodriguez, Executive Director
Village for Families & Children
1680 Albany Ave
Hartford, CT 06105

FROM: Sandra C. Bauer, Licensing Examination Assistant

DATE: August 3, 2011

Enclosed is your license to operate a Facility for the Care or Treatment of Substance Abusive Persons.

The license must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Division of Health Systems Regulation must be notified immediately if you:

1. Change the Executive Director.
2. Plan any structural changes.
3. Plan to move.
4. Plan to sell the facility.
5. Plan to discontinue operation.
6. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

If I can be of any assistance, please do not hesitate to contact me.

Enclosure(s)



Phone: (860) 509-8023 Fax: (860) 509-7538
Telephone Device for the Deaf (860) 509-7191
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STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0496

Psychiatric Outpatient Clinic for Adults

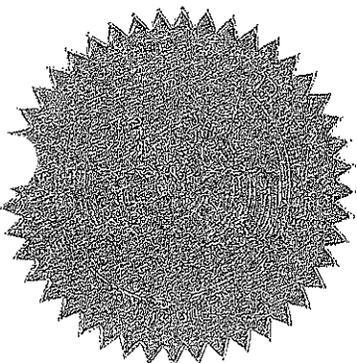
In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Village For Families & Children, Inc. of Hartford, CT, d/b/a Village For Families And Children is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Village for Families & Children, Inc is located at 105 Spring St, Hartford, CT 06105 with:

Galo Rodriguez as Executive Director
Regina M. Moller as Director

This license expires **March 31, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, April 7, 2011. INITIAL.



Jewel Mullen, MD

Jewel Mullen, MD, MPH, MPA
Commissioner

000134



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Galo Rodriguez, Executive Director
Village for Families & Children
1680 Albany Ave
Hartford, CT 06105

FROM: Sandra C. Bauer, Licensing Examination Assistant

DATE: April 8, 2011

Enclosed is your license to operate a **Psychiatric Outpatient Clinic for Adults**.

It must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Facility Licensing & Investigations Section **must be notified immediately** if you:

1. Change the Executive Director
2. Change the Director
3. Plan any structural changes
4. Plan to move
5. Plan to sell the facility
6. Plan to discontinue operation
7. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

Please contact me if I can be of any assistance

Enclosure(s)



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STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0357

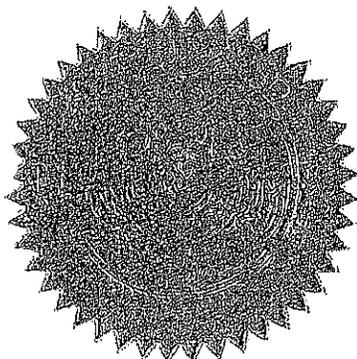
Psychiatric Outpatient Clinic for Adults

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
Village for Families & Children, Inc. of Hartford, CT, d/b/a Village for Families & Children, Inc. is
hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Village for Families & Children, Inc. is located at 331 Wethersfield Avenue, Hartford, CT 06114 with

Galo Rodriguez as Executive Director
Regina M. Moller as Director

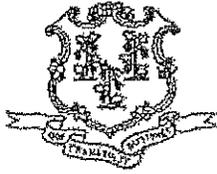
This license expires **March 31, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, April 1, 2011. RENEWAL.



Jewel Mullen

Jewel Mullen, MD, MPH, MPA
Commissioner

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Laurie Valentine, LCSW, Director of Compliance & Privacy
The Village for Families & Children
1680 Albany Ave
Hartford, CT 06105

FROM: Sandra C. Bauer, Licensing Examination Assistant

DATE: March 14, 2011

Enclosed is your license to operate a **Psychiatric Outpatient Clinic for Adults**.

It must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Facility Licensing & Investigations Section **must be notified immediately** if you:

1. Change the Executive Director
2. Change the Director
3. Plan any structural changes
4. Plan to move
5. Plan to sell the facility
6. Plan to discontinue operation
7. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

Please contact me if I can be of any assistance

Enclosure(s)



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STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C-0091

Psychiatric Outpatient Clinic for Adults

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Village For Families & Children, Inc. of Hartford, CT, d/b/a Village For Families And Children is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Village for Families And Children is located at 1680 Albany Ave, Hartford, CT 06105 with:

Galo Rodriguez as Executive Director

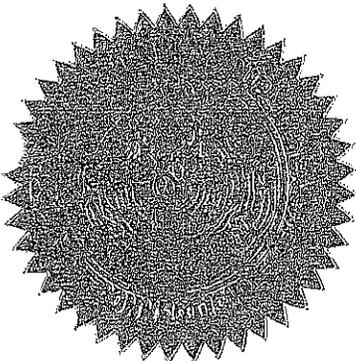
Regina M. Moller as Director

The service classification(s) and if applicable, the residential capacities are as follows:

Multi Service

This license expires **September 30, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. RENEWAL.



Jewel Mullen MD

Jewel Mullen, MD, MPH, MPA
Commissioner

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

TO: Galo Rodriguez, Executive Director
Village for Families & Children
1680 Albany Ave
Hartford, CT 06105

FROM: Sandra C. Bauer, Licensing Examination Assistant

DATE: August 3, 2011

Enclosed is your license to operate a **Psychiatric Outpatient Clinic for Adults**.

It must be posted in a conspicuous place as required by the General Statutes of Connecticut, Section 19a-493.

The license is in effect only for the operation of the facility as it is now organized. The Facility Licensing & Investigations Section **must be notified immediately** if you:

1. Change the Executive Director
2. Change the Director
3. Plan any structural changes
4. Plan to move
5. Plan to sell the facility
6. Plan to discontinue operation
7. Plan to change services.

Any of these changes or proposed changes also requires written notification to this division.

Please contact me if I can be of any assistance

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APPENDIX G

2010 Audit

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To the Finance Committee
The Village for Families & Children, Inc.

We have audited the financial statements of The Village for Families & Children, Inc. (the Corporation) for the year ended June 30, 2010 and have issued our report thereon dated October 11, 2010. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America, OMB Circular A-133, and the State Single Audit Act

As stated in our engagement letter dated May 5, 2010, our responsibility, as described by professional standards, is to express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we considered the Corporation's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. We also considered internal control over compliance with requirements that could have a direct and material effect on a major federal or state program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133 and the State Single Audit Act.

As part of obtaining reasonable assurance about whether the Corporation's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit. Also, in accordance with OMB Circular A-133 and the State Single Audit Act, we examined, on a test basis, evidence about the Corporation's compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Circular A-133 Compliance Supplement* applicable to each of its major federal programs, and the compliance requirements described in the *Compliance Supplement to the State Single Audit Act* applicable to each of its major state programs for the purpose of expressing an opinion on the Corporation's compliance with those requirements. While our audit provides a reasonable basis for our opinion, it does not provide a legal determination on the Corporation's compliance with those requirements.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our memo about planning matters on July 29, 2010.

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. In accordance with the terms of our engagement letter, we will advise management about the appropriateness of accounting policies and their application. The significant accounting policies used by the Corporation are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year. We noted no transactions entered into by the Corporation during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimate affecting the financial statements was as follows:

Management's estimate of the allowance for doubtful accounts is based on historical experience. We evaluated the key factors and assumptions used to develop the allowance for doubtful accounts in determining that it is reasonable in relation to the financial statements taken as a whole.

The disclosures in the financial statements are neutral, consistent and clear. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. There were no sensitive disclosures affecting the financial statements.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the

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misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditors' report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 11, 2010.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Corporation's financial statements or a determination of the type of auditors' opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Corporation's auditors. However, these discussions occurred in the normal course of our professional relationship, and our responses were not a condition to our retention.

This information is intended solely for the use of the Finance Committee and management of The Village for Families & Children, Inc., and is not intended to be and should not be used by anyone other than these specified parties.

Blum, Shapiro & Company, P.C.

October 11, 2010

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THE VILLAGE FOR FAMILIES & CHILDREN, INC.

FINANCIAL STATEMENTS

JUNE 30, 2010

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THE VILLAGE FOR FAMILIES & CHILDREN, INC.

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Independent Auditors' Report

Board of Directors
The Village for Families & Children, Inc.
Hartford, Connecticut

We have audited the accompanying statement of financial position of The Village for Families & Children, Inc., as of June 30, 2010 and the related statements of activities, functional expenses and cash flows for the year then ended. These financial statements are the responsibility of The Village for Families & Children, Inc.'s management. Our responsibility is to express an opinion on these financial statements based on our audit. The prior year summarized comparative information has been derived from the Corporation's 2009 financial statements, and, in our report dated October 21, 2009, we expressed an unqualified opinion on those financial statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The Village for Families & Children, Inc., at June 30, 2010 and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated October 11, 2010 on our consideration of The Village for Families & Children, Inc.'s internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in conjunction with this report in considering the results of our audit.

Blum, Shapiro & Company, P.C.

October 11, 2010

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
STATEMENT OF FINANCIAL POSITION
JUNE 30, 2010
With Summarized Financial Information for 2009
(In Thousands)

	<u>2010</u>	<u>2009</u>
ASSETS		
Current Assets		
Cash and cash equivalents	\$ 1,061	\$ 2,664
Investments	18,895	16,453
Assets held by bond trustee	1,534	1,559
Accounts receivable, net	1,045	1,406
Pledges receivable, net	74	49
Prepaid expenses	237	100
Custodial asset	14	-
Total current assets	<u>22,860</u>	<u>22,231</u>
Land, Buildings and Equipment , Net of Accumulated Depreciation	14,871	15,208
Other Assets		
Beneficial interest in perpetual trusts	46,492	43,806
Pledges receivable, net	-	98
Bond issuance costs, net of accumulated amortization	<u>611</u>	<u>638</u>
Total Assets	<u>\$ 84,834</u>	<u>\$ 81,981</u>
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable and accrued expenses	\$ 2,115	\$ 2,040
Current portion of bond payable	310	300
Deferred revenue	254	209
Custodial liability	14	-
Total current liabilities	<u>2,693</u>	<u>2,549</u>
Noncurrent Liabilities		
Bonds payable, net of current portion	12,040	12,350
Unamortized bond premium	70	73
Accrued pension obligation	<u>5,028</u>	<u>4,560</u>
Total current liabilities	<u>17,138</u>	<u>16,983</u>
Total liabilities	<u>19,831</u>	<u>19,532</u>
Net Assets		
Unrestricted:		
Funds functioning as endowment	17,715	17,861
Temporarily restricted	190	231
Permanently restricted	<u>47,098</u>	<u>44,357</u>
Total net assets	<u>65,003</u>	<u>62,449</u>
Total Liabilities and Net Assets	<u>\$ 84,834</u>	<u>\$ 81,981</u>

The accompanying notes are an integral part of the financial statements

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THE VILLAGE FOR FAMILIES & CHILDREN, INC.
STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED JUNE 30, 2010
With Summarized Financial Information for 2009
(In Thousands)

	2010			Total 2009
	Unrestricted	Temporarily Restricted	Permanently Restricted	
Support and Revenue				
Public support:				
United Way	\$ 673	\$ -	\$ -	\$ 673
Contributions	695	120	-	815
Total public support	<u>1,368</u>	<u>120</u>	<u>-</u>	<u>1,488</u>
Revenues:				
Program fees	5,570	-	-	5,570
Grants and contracts	12,597	-	-	12,597
Investment income	2,424	-	-	2,424
Net realized and unrealized gains (losses) on investment transactions	1,566	54	-	1,620
Change in the value of perpetual trusts	-	-	2,686	2,686
Other income	196	-	-	196
Net assets released from restriction	215	(215)	-	-
Total revenues	<u>22,568</u>	<u>(161)</u>	<u>2,686</u>	<u>25,093</u>
Total support and revenue	<u>23,936</u>	<u>(41)</u>	<u>2,686</u>	<u>26,581</u>
Expenses				
Program services:				
Children's services	15,296	-	-	15,296
Neighborhood and family strengthening services	3,560	-	-	3,560
Research and training	277	-	-	277
Total program services	<u>19,133</u>	<u>-</u>	<u>-</u>	<u>19,133</u>
Supporting services:				
Fund raising	638	-	-	638
General and administrative	4,256	-	-	4,256
Total supporting services	<u>4,894</u>	<u>-</u>	<u>-</u>	<u>4,894</u>
Total expenses	<u>24,027</u>	<u>-</u>	<u>-</u>	<u>24,027</u>
Net Increase (Decrease) in Net Assets	(91)	(41)	2,686	(19,024)
Net Assets - Beginning of Year	17,861	231	44,357	62,449
Reclassification of Net Assets	(55)	-	55	-
Net Assets - End of Year	<u>\$ 17,715</u>	<u>\$ 190</u>	<u>\$ 47,098</u>	<u>\$ 65,003</u>

The accompanying notes are an integral part of the financial statements

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED JUNE 30, 2010
 With Summarized Financial Information for 2009
 (In Thousands)

	2010					Total 2009
	Program Services			Support Services		
	Neighborhood and Family Strengthening Services		Research and Training	Fund Raising	General and Administrative	Grand Total
Children's Services	\$	\$	\$	\$	\$	\$
Salaries with benefits and taxes	10,823	2,644	80	471	2,215	16,233
Professional fees	366	154	-	-	203	723
Audit/legal fees	-	-	-	-	52	52
Board Foster Care	1,035	-	-	-	-	1,035
Insurance	130	44	-	4	18	196
Utilities	344	67	1	15	67	494
Rent	29	22	-	33	-	84
Supplies	431	169	1	30	56	687
Account fees	-	-	-	-	33	33
Occupancy and services	647	119	29	37	209	1,041
Agency vehicles	161	9	-	1	2	173
Training	24	70	6	1	41	142
Organizational dues	2	1	2	-	35	40
Mileage costs - staff	42	6	-	-	-	48
Activities	88	61	-	26	42	217
All other expenses	392	66	96	20	158	732
Total expenses before depreciation, amortization and pension expense	14,514	3,432	215	638	3,131	21,930
Depreciation and amortization	782	128	62	-	11	983
Pension expense	-	-	-	-	1,114	1,114
Total	\$ 15,296	\$ 3,560	\$ 277	\$ 638	\$ 4,256	\$ 24,027

The accompanying notes are an integral part of the financial statements

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THE VILLAGE FOR FAMILIES & CHILDREN, INC.
STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED JUNE 30, 2010
With Summarized Financial Information for 2009
(In Thousands)

	2010	2009
Cash Flows from Operating Activities		
Increase (decrease) in net assets	\$ 2,554	\$ (19,024)
Adjustments to reconcile increase (decrease) in net assets to net cash used in operating activities:		
Net realized and unrealized (gains) losses on investments	(1,620)	5,017
Reinvested dividend and interest income	(393)	-
Depreciation and amortization	983	994
Amortization of bond premium	(3)	(4)
(Increase) decrease in value of perpetual trusts	(2,686)	8,473
(Increase) decrease in operating assets:		
Accounts receivable	361	855
Pledges receivable	73	(98)
Prepaid expenses	(137)	(22)
Increase (decrease) in operating liabilities:		
Accounts payable and accrued expenses	120	(845)
Accrued pension obligation	468	3,902
Net cash used in operating activities	(280)	(752)
Cash Flows from Investing Activities		
Purchase of land, buildings and equipment	(619)	(734)
Purchase of investments	(495)	(1,400)
Proceeds from sale of investments	66	5,022
(Increase) decrease in assets held by bond trustee	25	(3)
Net cash provided by (used in) investing activities	(1,023)	2,885
Cash Flows from Financing Activities		
Payments on bond payable	(300)	(285)
Net cash used in financing activities	(300)	(285)
Net Increase (Decrease) in Cash and Cash Equivalents	(1,603)	1,848
Cash and Cash Equivalents - Beginning of Year	2,664	816
Cash and Cash Equivalents - End of Year	\$ 1,061	\$ 2,664
Cash Paid During the Year for Interest	\$ 602	\$ 621

The accompanying notes are an integral part of the financial statements

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Corporation and Nature of Activities - The Village for Families & Children, Inc. (the Corporation) was created to provide social and mental health services, primarily in the Capital Region of Connecticut, to children and families, without regard to ability to pay. The Corporation served approximately 6,465 families and children during the year ended June 30, 2010. The Corporation presently receives and accepts public and private gifts, grants, loans and other funds in furtherance of its purpose. The Corporation was organized as a nonprofit organization that operates exclusively for charitable, scientific or educational purpose.

Prior Year Summarized Financial Information - The financial statements include certain prior year summarized financial information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with accounting principles generally accepted in the United States of America (GAAP). Accordingly, such information should be read in conjunction with the Corporation's audited financial statements as of and for the year ended June 30, 2009, from which the summarized information was derived.

Basis of Accounting and Presentation - The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with GAAP. Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of the Corporation and changes therein are classified and reported as follows:

Unrestricted Net Assets - Unrestricted net assets represent available resources other than donor-restricted contributions. These resources may be expended at the discretion of the Board of Directors.

Temporarily Restricted Net Assets - Temporarily restricted net assets represent contributions that are restricted by the donor as to purpose or time of expenditure and accumulated investment gains and income on donor-restricted endowment assets.

Permanently Restricted Net Assets - Permanently restricted net assets represent resources that have donor-imposed restrictions that require that the principal be maintained in perpetuity but permit the Corporation to expend the income earned thereon.

Use of Estimates - The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Cash and Cash Equivalents - Cash equivalents are defined as highly liquid investments with original maturities of 90 days or less. Restricted cash is limited in use for payment of costs related to the Wraparound program on behalf of the Department of Children and Families. Terms of this agreement require that funds be segregated in a separate bank account from other Corporation funds. The Corporation maintains deposits in financial institutions that may, at times, exceed federal depository insurance limits. Management believes that the Corporation's deposits are not subject to significant credit risk.

Investments - Investments in marketable debt and equity securities, money market funds and mutual funds with readily determinable fair values are stated at fair value in the statement of financial position. Realized and unrealized gains and losses and investment income on donor-restricted endowment assets are classified as increases and decreases in temporarily restricted net assets until appropriated for expenditure.

Accounts Receivable - The Corporation has accounts receivable related to grants and third-party reimbursements. Third-party reimbursement receivables are considered delinquent after one year and are written off after standard collection procedures are exhausted. Management maintains an allowance for doubtful accounts based on a review of specific accounts and general historical experience.

Property and Equipment - Property and equipment acquisitions and improvements thereon that exceed \$2,000 are capitalized at cost and depreciated on a straight-line basis over their estimated useful lives. Repairs and maintenance are charged to expense as incurred.

Beneficial Interest in Perpetual Trusts - The Corporation is the beneficiary of various perpetual trusts held by and administered by Bank of America. In accordance with these trusts, the Corporation has an irrevocable right to receive the income earned from the trusts' assets in perpetuity. The Corporation will never receive the trusts' corpus, and, therefore, the assets are reported as permanently restricted net assets. In addition, the annual investment income received from these trusts is recorded in the unrestricted fund in accordance with the trusts. The income from the trusts for the years ended June 30, 2010 and 2009, was \$2,010 and \$2,063, respectively. Changes in the carrying amount of the beneficial interest are recognized as increases or decreases in permanently restricted net assets.

Bond Issuance Costs - Bond issuance costs are amortized over the life of the related bond issue. Amortization expense for each of the years ended June 30, 2010 and 2009, was \$27. Future expected amortization costs for each the next five years is \$27.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Contributions - Unconditional contributions are recognized when pledged or received, as applicable, and are considered to be available for unrestricted use unless specifically restricted by the donor. The Corporation reports nongovernmental contributions and grants of cash and other assets as temporarily restricted support if they are received with donor stipulations that limit their use. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions. Conditional promises to give are recognized when the conditions on which they depend are substantially met.

No amounts have been reflected in the financial statements for donated services as the services do not require specialized expertise. The Corporation pays for most services requiring specific expertise. However, many individuals volunteer their time and perform a variety of tasks that assist the Corporation.

Grants and Contracts - Other than certain awards to fund capital expenditures, governmental grants and contracts are generally considered to be exchange transactions rather than contributions. Revenue from cost-reimbursement grants and contracts is recognized to the extent of costs incurred. Revenue from performance-based grants and contracts is recognized to the extent of performance achieved. Grant and contract receipts in excess of revenue recognized are presented as deferred revenue.

Income Taxes - The Corporation is exempt from federal and state income taxes as a public charity under Section 501(c)(3) of the Internal Revenue Code. However, the Corporation is subject to unrelated business income taxes related to its real estate rental, and such taxes are included in management and general expenses in the statement of activities. The Corporation's informational and tax returns for the years ended June 30, 2007 through June 30, 2010 are subject to examination by the Internal Revenue Service and the State of Connecticut.

Reclassifications - Certain amounts reported in 2009 have been reclassified in order to conform to the current year presentation. In connection with the continuous review of the Connecticut Prudent Management of Institutional Funds Act (CTPMIFA), management continues to perform a comprehensive analysis of the Corporation's net assets and reclassified certain funds in order to properly reflect donor intent. The reclassification is shown as a reclassification of net assets on the accompanying statement of activities.

Subsequent Events - In preparing these financial statements, management has evaluated subsequent events through October 11, 2010, which represents the date the financial statements were available to be issued. See Note 17 for additional documentation on subsequent event activity.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 2 - FAIR VALUE

The carrying amounts reflected in the accompanying statement of financial position for cash and cash equivalents, assets held by bond trustee and accounts receivable approximate the respective fair values due to the short maturities of those instruments. Investments are recorded at fair value as discussed in Note 1, and as presented in the table below. The fair value of pledges receivable are estimated based upon the net present value of estimated cash flows discounted at a treasury rate commensurate with the timing of the estimated cash flow. Beneficial interests in trusts are measured at the present value of expected future cash flows.

The levels of valuation inputs under GAAP for financial instruments carried at fair value are as follows:

Level 1 - Quoted market prices for identical assets on an active market to which an entity has access at the measurement date.

Level 2 - Inputs and information other than quoted market indices included in Level 1 that are observable for the asset, either directly or indirectly, and the Corporation has the ability to redeem the asset in the near term subsequent to the measurement date.

Level 3 - Unobservable inputs for the asset. Unobservable inputs should be used to measure the fair value to the extent that observable inputs are not available, and the Corporation does not have the ability to redeem the asset in the near term.

Assets Measured at Fair Value on a Recurring Basis - The following is a summary of the source of fair value measurements for assets that are measured at fair value on a recurring basis:

<u>Description</u>	<u>June 30,</u> <u>2010</u>	<u>Fair Value Measurements Using</u>		
		<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Investments:				
Bonds	\$ 7,179	\$ 7,179	\$ -	\$ -
Equity	11,716	11,716	-	-
Beneficial interests in trusts	46,492	-	-	46,492

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 2 - FAIR VALUE (Continued)

Assets Measured at Fair Value on a Recurring Basis Using Significant Unobservable Inputs (Level 3) - The following is a summary of the changes in the balances of investments measured at fair value on a recurring basis using significant unobservable inputs:

		<u>Beneficial Interest in Trusts</u>
Balance - beginning of year	\$	43,806
Total realized and unrealized gains included in the change in net assets		<u>2,686</u>
Balance - End of Year	\$	<u><u>46,492</u></u>

Total gains for the period included in changes in net assets attributable to the change in unrealized gains or losses relating to assets still held at year end were \$2,686.

NOTE 3 - ACCOUNTS RECEIVABLE

Accounts receivable consists of the following as of June 30, 2010 and 2009:

	<u>2010</u>		<u>2009</u>
Grants and contracts	\$ 536	\$	502
Third party	335		523
Other	76		318
Government fees - DCF	70		202
Government fees - Education	71		76
Self pay	43		18
Total accounts receivable	<u>1,131</u>		<u>1,639</u>
Less allowance for doubtful accounts	<u>86</u>		<u>233</u>
Net Accounts Receivable	<u>\$ 1,045</u>	\$	<u><u>1,406</u></u>

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 4 - PLEDGES RECEIVABLE

Pledges receivable as of June 30, 2010 and 2009, are expected to be collected as follows:

	<u>2010</u>	<u>2009</u>
Receivable in less than one year	\$ 139	\$ 69
Receivable in one to five years	-	137
Total contributions receivable	<u>139</u>	<u>206</u>
Less allowance for uncollectible accounts	<u>65</u>	<u>59</u>
Net Pledges Receivable	<u>\$ 74</u>	<u>\$ 147</u>

NOTE 5 - LAND, BUILDINGS AND EQUIPMENT

The carrying values of land, buildings and equipment at June 30, 2010 and 2009, are summarized as follows:

	<u>2010</u>	<u>2009</u>
Land	\$ 185	\$ 185
Buildings and improvements	22,227	21,835
Equipment and automobiles	<u>6,391</u>	<u>6,164</u>
	28,803	28,184
Less accumulated depreciation	<u>13,932</u>	<u>12,976</u>
Net Land, Buildings and Equipment	<u>\$ 14,871</u>	<u>\$ 15,208</u>

Depreciation expense for the years ended June 30, 2010 and 2009, was \$956 and \$966, respectively.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 6 - BONDS PAYABLE

The Corporation entered into a loan agreement on November 1, 2002 with the State of Connecticut Health and Educational Facilities Authority (CHEFA) in connection with the following variable rate bond obligations:

State of Connecticut Health and Educational Facilities Authority Revenue Bonds, The Village for Families and Children, Inc., Series A (Original amount of \$13,660)

State of Connecticut Health and Educational Facilities Authority Revenue Bonds, The Village for Families and Children, Inc., Series B (Original amount of \$340)

The bonds bear interest at a fixed rate of 4% through 2014, at which time the rate is fixed at 5% for the remainder of the bonds' terms. Interest expense amounted to \$602 and \$621 for the years ended June 30, 2010 and 2009, respectively. The fair value of bonds payable is based on the interest rate currently available to the Corporation for loans with similar maturities and credit quality. Management estimates that the carrying value of the bonds approximated fair value at June 30, 2010 and 2009.

The proceeds from the debt arrangement were used together with other sources to acquire and renovate a facility located at 331 Wethersfield Avenue, Hartford, Connecticut, which is used as an administrative office space and provides family-oriented social services.

In accordance with the bond indenture, the Corporation has set aside with the bond trustee certain required amounts to meet future debt service obligations. At June 30, 2010 and 2009, these funds amounted to \$1,534 and \$1,559, respectively. Annual principal installments (due July 1, following the year end) and total interest on the bonds required under the loan agreement are as follows:

<u>Year Ending June 30,</u>	<u>Principal Installments</u>
2011	\$ 310
2012	320
2013	335
2014	345
2015	355
Thereafter	<u>10,685</u>
	<u>\$ 12,350</u>

Covenants - The bonds' provisions include, among other provisions, restrictions on indebtedness and requirements that the Corporation meet certain financial and other covenants.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 7 - OPERATING LEASES

The Corporation entered into an operating lease agreement for a facility at 2550 Main Street, Hartford, Connecticut, and a second agreement for a facility in Manchester, Connecticut.

The lease at 2550 Main Street expired in 2010 and was not renewed. The Corporation is currently in negotiations to renew the lease in Manchester, which expired in 2010. Rent expense for these leases was \$110 and \$90 for the years ended June 30, 2010 and 2009, respectively.

Additionally, eight operating leases are outstanding on vehicles used for transporting the Corporation's clients. The terms of these leases are on a year-to-year basis. Rent expense for the leases was \$104 and \$114 for the years ended June 30, 2010 and 2009, respectively.

NOTE 8 - PENSION PLANS

Defined Contribution Plan - The Corporation sponsors a defined contribution plan with a non-contributory component which covers substantially all employees, and it matches qualifying employee contributions up to a certain level. Defined contribution expense for the years ended June 30, 2010 and 2009, was \$187 and \$241, respectively

Defined Benefit Plan - On June 30, 2006, the Corporation had a noncontributory defined benefit plan covering substantially all full-time employees after they completed 1 year of service and attained the age of 21. The plan was sponsored by the Corporation, administered by the President and CEO, and was subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Effective June 30, 2006, benefit accruals on the defined benefit plan were frozen with no further accrual of future benefits and no additional participants entering the Plan. Therefore, the final average earnings of participants are determined as if the participant terminated employment on June 30, 2006.

Under the terms of the plan, participants were fully vested after 5 years of service and are eligible for pension benefits upon retirement at age 65. Eligible employees are entitled to pension benefits based on a percentage of average final earnings (less 50% of Social Security benefits) and years of credited service. Early retirement was provided for those employees who reached the age of 50 with 10 years of credited service. Benefits under the plan are in the form of monthly life annuities for participants retired prior to November 1995 and, thereafter, directly from plan assets. The Corporation's funding policy is to contribute annually at least the minimum amount required by ERISA, as determined by the plan actuary.

In accordance with GAAP, the Corporation is required to record a liability on the statement of financial position for the underfunded portion of its postretirement plans, defined as the amount by which the projected benefit obligation exceeds the fair value of the plan assets.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 8 - PENSION PLANS (Continued)

Obligations and Funded Status - The following table sets forth the plan's funded status and amounts recognized in the accompanying statement of financial position as of June 30, 2010 and 2009:

	<u>Pension Benefits</u>	
	<u>2010</u>	<u>2009</u>
Change in benefit obligation:		
Projected benefit obligation at beginning of year	\$ (16,491)	\$ (15,133)
Interest cost	(1,005)	(993)
Experience loss	(1,416)	(1,061)
Benefits paid	789	696
Benefit obligation at end of year	<u>(18,123)</u>	<u>(16,491)</u>
Change in plan assets:		
Fair value of plan assets at beginning of year	11,931	14,475
Actual return on plan assets	1,307	(1,848)
Employer contributions	646	-
Benefits paid	(789)	(696)
Fair value of plan assets at end of year	<u>13,095</u>	<u>11,931</u>
Unfunded Status	\$ <u>(5,028)</u>	\$ <u>(4,560)</u>
Accrued Pension Obligation	\$ <u>(5,028)</u>	\$ <u>(4,560)</u>

Net periodic pension costs for the defined benefit plan include the following components at June 30, 2010 and 2009:

	<u>Pension Benefits</u>	
	<u>2010</u>	<u>2009</u>
Components of net periodic benefit cost:		
Interest cost	\$ 1,005	\$ 993
Recognized loss	175	3
Expected return on plan assets	<u>(1,077)</u>	<u>(1,136)</u>
Net Periodic Pension Cost (Income)	\$ <u>103</u>	\$ <u>(140)</u>

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 8 - PENSION PLANS (Continued)

Assumptions used to determine benefit obligation and net periodic benefit cost of the defined benefit plan at June 30, 2010 and 2009, were as follows:

	<u>2010</u>	<u>2009</u>
Weighted-average assumptions:		
Discount rate	5.50%	6.25%
Expected return of plan assets for the year	N/A	8.0

Estimated Future Benefit Payments - The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

2011	\$ 907
2012	997
2013	1,057
2014	1,091
2015	1,079
2016-2020	5,690

Plan Assets - The percentage of the fair value of total plan assets held as of June 30, 2010 and 2009, by asset category is as follows:

	<u>2010</u>	<u>2009</u>
Equities	57%	55%
Fixed income	43%	45%

The Corporation's investment strategy is based on a portfolio comprised of assets held in mutual funds, with a targeted asset mix of 60% in equities and 40% in fixed income funds at June 30, 2010 and 2009. Investments are held in mutual funds with the intent of diversifying individual investment positions to minimize the risk of large losses to the plan. The asset mix was determined by evaluating the expected return against the plan's long-term objectives. Performance is monitored by the Finance Committee on a monthly basis, and the allocation of assets is rebalanced when necessary to ensure the allocations are within 5% of the target range. The Finance Committee monitors the investment performance annually to determine the continued feasibility of achieving the investment objectives and the appropriateness of the investment policy.

Cash Flows - Cash contributions made to the plan for the year ended June 30, 2010 were \$646. There were no contributions made for the year ended June 30, 2009.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 9 - TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets at June 30, 2010 and 2009, are restricted for the following purposes:

	2010	2009
Bicentennial Campaign	\$ 130	\$ 206
Latino Outreach Program	-	20
Family Financial Literacy	3	-
Adoption Program	2	5
Home Away From Home	1	-
Accumulated gains and income available for appropriation by the Board of Directors	54	-
	\$ 190	\$ 231

NOTE 10 - NET ASSETS RELEASED FROM RESTRICTIONS

Net assets were released from restrictions by incurring expenses satisfying the following purpose restrictions for the years ended June 30, 2010 and 2009:

	2010	2009
Bicentennial Campaign	\$ 190	\$ -
Latino Outreach Program	20	-
Adoption Program	3	3
Family Financial Literacy	2	-
	\$ 215	\$ 3

NOTE 11- PERMANENTLY RESTRICTED NET ASSETS

The amount reflected as permanently restricted net assets at June 30, 2010 and 2009, is comprised of the following:

	2010	2009
Beneficial interest in perpetual trusts	\$ 46,492	\$ 43,806
Donor-restricted endowment	606	551
	\$ 47,098	\$ 44,357

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 12 - ENDOWMENT

The Corporation's endowment includes both donor-restricted endowment funds and funds designated by the Board of Directors to function as endowments. The income earned on investments comprising the Corporation's donor-restricted endowment funds is restricted to subsidize children and family service programs. As required by GAAP, net assets associated with endowment funds, including funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law - The Board of Directors of the Corporation has interpreted CTPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Corporation in a manner consistent with the standard of prudence prescribed by CTPMIFA. In accordance with CTPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- The duration and preservation of the fund
- The purposes of the organization and the donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the organization
- The investment policies of the organization

Endowment Net Assets - Endowment net asset composition by type of fund is as follows as of June 30, 2010:

	<u>Unrestricted</u>	<u>Temporarily Restricted</u>	<u>Permanently Restricted</u>	<u>Total</u>
Donor-restricted endowment funds	\$ -	\$ 54	\$ 606	\$ 660
Board-designated endowment funds	<u>17,715</u>	<u>-</u>	<u>-</u>	<u>17,715</u>
Total	<u>\$ 17,715</u>	<u>\$ 54</u>	<u>\$ 606</u>	<u>\$ 18,375</u>

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 12 - ENDOWMENT (Continued)

Changes in endowment net assets for the year ended June 30, 2010 are as follows:

	<u>Unrestricted</u>	<u>Temporarily Restricted</u>	<u>Permanently Restricted</u>	<u>Total</u>
Endowment net assets - beginning of year	\$ 17,861	-	\$ 551	\$ 18,412
Reclassifications	(55)	-	55	-
Investment return:				
Investment income	2,424	-	-	2,424
Investment gains	1,566	54	-	1,620
Total investment return	3,990	54	-	4,044
Contributions	1,368	-	-	1,368
Expenditure of endowment assets	(5,449)	-	-	(5,449)
Endowment Net Assets - End of Year	\$ 17,715	54	\$ 606	\$ 18,375

Funds with Deficiencies - From time to time, the fair value of investments associated with donor-restricted endowment funds may fall below the level that the donor or CTPMIFA requires the Corporation to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature that are reported in unrestricted net assets were \$89 as of June 30, 2009. There were no such deficiencies as of June 30, 2010.

Return Objectives and Risk Parameters - The Corporation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include donor-restricted assets that the Corporation must hold in perpetuity as well as board-designated funds. Under this policy, as approved by the Board of Directors, endowment assets are invested in a manner that is intended to meet the Corporation's primary objective of preservation of capital and secondary objective of long-term capital appreciation.

Strategies Employed for Achieving Objectives - To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation targets a diversified asset allocation that places a greater emphasis on fixed income investments to achieve its primary long-term objective of preservation of capital.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 12 - ENDOWMENT (Continued)

Spending Policy and How the Investment Objectives Relate to Spending Policy - The Corporation's spending policy limits annual spending to no more than 5% of the three-year average balance of the endowment investments plus the designation of ½% of the three-year average endowment as a capital reserve, unless otherwise approved by the Finance Committee and Board. Expenditures from the capital reserve will be made at the discretion of the Finance Committee with the approval of the Board. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity, as well as to provide additional real growth through new gifts and investment return.

NOTE 13 - FUNCTIONAL ALLOCATION OF EXPENSES

The costs of providing the various programs and other activities have been summarized on a functional basis in the statement of functional expenses. These costs include direct and indirect costs that have been allocated, on a consistent basis, among the program and supporting services benefited.

NOTE 14 - REVENUE CONCENTRATION

The Corporation relies heavily upon the State of Connecticut Department of Children and Families as it provides approximately 33% and 35% as of June 30, 2010 and 2009, respectively, of its total unrestricted public support and revenues. As with all government funding, these grants and contracts are subject to reduction or termination in future years. Any significant reduction in these grants and contracts could have an adverse effect on the Corporation's program services.

NOTE 15 - RELATED PARTIES

There are several auxiliary corporations whose primary purpose is to render voluntary assistance and raise funds for the Corporation. The public support of \$227 from these auxiliaries is included in contributions on the statement of activities.

NOTE 16 - COMMITMENTS AND CONTINGENCIES

The Corporation participates in a number of federal and state assisted programs. The use of the grants in programs is subject to future review by the grantors. Such reviews may result in the Corporation having liabilities to the grantors.

THE VILLAGE FOR FAMILIES & CHILDREN, INC.
NOTES TO FINANCIAL STATEMENTS
(Amounts Expressed in Thousands)

NOTE 17 - SUBSEQUENT EVENTS

On July 1, 2010, The Village for Families & Children, Inc., signed an Affiliation Agreement with The Shelter for Women, Inc. In this agreement, The Village for Families & Children, Inc., will become the sole member of The Shelter for Women, Inc., making the Shelter a corporate subsidiary of The Village for Families & Children, Inc.

Bryden, Liz

Subject: Canceled: OCHA Application for Eagle Mails Today
Location: (20 days after last day of Public Notice in paper)

Start: Thu 3/24/2011 7:30 AM
End: Thu 3/24/2011 7:30 AM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Importance: High

Hi Yvete and Liz

The OCHA Application can mail 20 days after the third day of Public Notice in paper. Our Public Notice went in for 3/1-3/3/11, so I counted off the required 20 days after that to determine when the full Application can be mailed. This is our reminder of the application mailing due date.

) Laurie

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