PROGRAMMATIC CONSULTATION FY21

REQUIRED Forms/Documents

The following forms are REQUIRED to be completed as part of the Programmatic Consultation process, meaning there is a direct data variable linked to our evaluation of model fidelity for each form. They are listed in the order that they are discussed in the SEC Curriculum that details the Programmatic Consultation processes.

Form/Document	Notes
1. Referral/Checklist	-May be completed by Resource Center staff then sent to SEC to facilitate communication.
2. Child Care Participation Agreement	-SEC gets signed by provider at first face to face meeting *If provider signs agreement then chooses NOT to participate in services, SEC completes EXIT form *If provider chooses to NOT participate in services BEFORE signing the agreement – make a note in case notes and do NOT complete EXIT form
3. Contact Log	-Complete within 24 hours of visit -Update throughout services - *final numbers will be asked for on the Exit Form*
4. Formal Observation/Assessment	- Complete within **30-45 days** of *Child Care Participation Agreement* signed by provider -Pre and Post- CHILD (Preschool center based rooms) -Pre and Post- TPITOS (Infant/Toddler center based rooms) -Pre and Post- CAREgiving checklist (HB providers) -No actual form – enter date and score into data base for Pre and Post assessment
5. Action Plan	-Plan to be completed **between 45-60 days** from initial referral -Review Action Plan every 3 months or every 10th visit
6. Satisfaction Survey for Providers	-*- Discuss with provider when first starting services to help explain expectations of service* - SEC to give to provider upon exiting services -Available by paper copy (with self-addressed stamped envelope) or email *if program has more than 1 case open simultaneously, give survey to provider after EACH exit. (Ex. provider has 2 CFF and 1 programmatic case open – survey is given to family and provider when *each* CFF case is exited- and when programmatic case is exited; reflecting services received for each case individually.
7. Community Trainings*	-Track all *formal* Community/Provider trainings in Excel Spreadsheet to be reported in Quarterly Narrative Reports in Egrams. *formal trainings are trainings above and beyond the typical consultation information sharing with providers. Generally, they are scheduled in 1-4 hour time slots and can be advertised within the community. *SEC must be registered in MiRegistry to provide community trainings. Ask your Resource Center staff for details.

Social Emotional Consultation Referral Form FY21

(Fillable PDF available on website: Printable Forms)

Date of referral (mm/dd/yyyy): __ __/ __ __/ __ __ __ __	
Provider name:	License number:
Who initiated the referral? ☐ Resource Center Staff ☐ SEC ☐ Self-Referral ☐ SUD Coordinator/Specialist ☐ Other, specify: ________________________	Name of person who initiated the referral (first & last): Contact number of person who initiated the referral: (__ __ __) __ __ __ - __ __ __ __
Type(s) of consultation requested: ☐ Programmatic Consultation ☐ Child/Family Focused Consultation ☐ Unsure/Undecided	Was the SEC referral Checklist (included in this form) completed? ☐ Yes ☐ No

PROVIDER CONTACT INFORMATION		
Date provider information collected (mm/dd/yyyy):	Provider type: ☐ Licensed Center ☐ Enrolled Subsidized Unlicensed ☐ Registered Family Home ☐ Provisional License ☐ Licensed Group Home ☐ Licensed exempt (Family, Friend, Neighbor)	Provider star rating (if applicable):
Provider street address : PO Box : City : State : Zip code : Office ph: ( )		
Name of director/registrant/licensee (first & last) : Ph: ( ) Cell: ( ) Email : Is the director/registrant/licensee the primary contact person for this provider? ☐ Yes ☐ No		
Name of primary contact person (first & last name): Ph: ( ) Cell: ( ) Email : *Communication preference : ☐ Call phone ☐ Call cell ☐ Text ☐ Email *Time of communication preference : ☐ AM ☐ PM ☐ Evening		
Initial Concern:		

SEC Referral Checklist FY21

Use this brief checklist to help you identify if a link to a social and emotional consultant might be helpful to your program. A checked box *to even one* of the criteria listed warrants an appropriate referral:

1. Staff need training to recognize social and emotional typical and atypical milestones.	☐
2. Staff need training in trauma/ACES/substance misuse in order to provide appropriate (trauma informed) care for infants, toddlers, young children and their families.	☐
3. Staff need support to screen children annually for social and emotional health using a published assessment tool like the Ages and Stages Questionnaire.	☐
4. Staff need more support when challenging behavior or situations (divorce, trauma, substance misuse, etc.) occur in our care setting and/or community.	☐
5. There is a child or children whose behavior or emotions are very frustrating or worrisome to staff/families.	☐
6. One or more staff feel stressed or burned out.	☐
7. One or more child(ren) has been asked to leave or had their day shortened in the past year.	☐
8. Moving from one activity to the next throughout the day feels chaotic or overwhelming to staff/child(ren).	☐
9. Staff are having trouble with or are concerned about certain families' well-being (divorce, traumatic events, substance misuse, etc.)	☐
10. Staff have difficulty getting along with one another and/or with families of children they care for.	☐
11. Children are reprimanded for expressing their emotions (e.g. "Stop crying, there is nothing to be sad about")?	☐
12. Staff need help to promote each child's unique temperament and developmental level (e.g. can active children explore freely, are slow to warm children given time to transition, etc.)?	☐
13. The provider needs support to write/implement a policy to prevent expulsion[1] and suspension for infants, toddlers and preschoolers (e.g. written documentation that all staff/families are aware of)?	☐
14. The provider needs support to write/implement a discipline/positive guidance policy in place (e.g. steps for how to support children with challenging behavior)?	☐

[1] *Expulsion* refers to terminating the enrollment of a child or family in the regular group setting because of challenging behaviors. *Suspension* includes all other reductions in the amount of time a child may attend-the regular group setting.

For RC Staff Only:	**YES**	**NO**
Was a referral made to the Social Emotional Consultant?	☐	☐
Date referral sent to SEC: Click here to enter a date.		
Notes: Click here to enter text.		

FY 21

CHILD CARE PARTICIPATION AGREEMENT

Child Care Program Name: ____

Date: ________________________

Social Emotional Consultation services are available to child care providers, to support increasing quality care around social and emotional health for children, staff and families. There is no cost to the provider for these services. There are two types of consultation services available. A provider may request one or both services.

- ☐ **Child-family focused consultation** for families and child care providers who wish to assist a child from birth through five years of age who is having emotional or behavioral difficulties at child care. This type of consultation involves: child observation and assessment; development of an Action Plan by the child's team (family; provider and consultant); and training and support for family and providers to implement the plan.

- ☐ **Programmatic consultation** to promote the social-emotional development of all infants, toddlers, preschoolers and staff in a child care program. This type of consultation involves: program assessment, development of a programmatic action plan, and training and support for staff to implement the plan.

As a participant in consultation services, your child care program has the following ***RIGHTS:***

- To receive fair, non-discriminatory services that respect the dignity of all staff and families.
- To receive confidential services.
- To receive free and voluntary services.
- To receive quality services that are regularly evaluated.
- To terminate services at any time.
- To decide whether or not to implement consultant's recommendations.

As a participant in consultation services, your child care program has the following ***RESPONSIBILITIES:***

- To maintain the confidentiality of the children and families receiving services.
- To make the areas where child care is provided available for observation by the consultant.
- To be available for *consistent and regular* face-to-face or phone meetings, including parent-provider meetings, if applicable.
- To complete a pre and post assessment, along with a final satisfaction survey.
- To contact the consultant within an appropriate timeframe, if it is necessary to cancel and reschedule observations or meetings.
- To implement those strategies agreed upon by a child's team and written in an Action Plan, if applicable.

As a representative of ____ (Child Care Program Name), I understand our ***rights and responsibilities*** and agree to participate in the consultation services as outlined above.

____

Name/Title (print)

____

Signature Date

Contact Log

<table>
<tr><td colspan="3">Provider Name:</td><td colspan="3">Consultant ID:</td></tr>
<tr><td>Date of attempt (mm/dd/yyyy):</td><td>Method of attempt:</td><td>Did you make contact?</td><td>What type of contact did you make? (select all that apply)</td><td>Length of consultation session in minutes, if applicable</td><td>Content of consultation, if applicable</td></tr>
<tr><td></td><td>❑ Phone
❑ Text ❑ Email
❑ Mail ❑ In-person
❑ Other (specify):
❑ Provider contacted consultant</td><td>❑ Yes
❑ No</td><td>❑ Consultation
❑ Scheduling
❑ Referral
❑ Other</td><td></td><td></td></tr>
<tr><td></td><td>❑ Phone
❑ Text ❑ Email
❑ Mail ❑ In-person
❑ Other (specify):
❑ Provider contacted consultant</td><td>❑ Yes
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❑ Referral
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❑ Scheduling
❑ Referral
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<tr><td></td><td>❑ Phone
❑ Text ❑ Email
❑ Mail ❑ In-person
❑ Other (specify):
❑ Provider contacted consultant</td><td>❑ Yes
❑ No</td><td>❑ Consultation
❑ Scheduling
❑ Referral
❑ Other</td><td></td><td></td></tr>
</table>

Programmatic Action Plan (Example)

Program Name:		Consultant ID:						
Strengths:	**Goal:**	**Steps/ Strategies:**	**Responsible Individuals:**	**Supplies:**	**Start date:**	**Target date:**	**End Date:**	**Quarterly Review:**
								❑ Goal met ❑ Goal modified ❑ Goal not met
								❑ Goal met ❑ Goal modified ❑ Goal not met

Strengths:	Goal:	Steps/ Strategies:	Responsible Individuals:	Supplies:	Start date:	Target date:	End Date:	Outcome:
								❑ Goal met ❑ Goal modified ❑ Goal not met

Immediate Intervention Strategies (to address crisis situations):

Community Referrals Needed:	Responsible Person	Target Date:

I am in agreement with the above proposed Action Plan.		
Name	**Signature**	**Role**

This plan was reviewed on the following dates:	Edits were made:	Initials of Participants
	❑ Yes ❑ No	
	❑ Yes ❑ No	
	❑ Yes ❑ No	
	❑ Yes ❑ No	
	❑ Yes ❑ No	

Satisfaction Survey for Child Care Providers

Date: ______________________________

Please help us improve our services by filling out this survey and returning it in the enclosed envelope. Your responses will be confidential. Your feedback is very important to us. Thank you in advance for your cooperation!

Please list your response for each item according to the scale below.

0=strongly disagree 1=disagree 2=neutral 3=agree 4=strongly agree N=not applicable / no opinion

1. The consultant responded to my referral in a timely manner. 0 1 2 3 4 N
2. The consultant's role was clearly explained to me. 0 1 2 3 4 N
3. I felt I had a good relationship with the consultant. 0 1 2 3 4 N
4. I believe that the consultation service was helpful. 0 1 2 3 4 N
5. I felt listened to by the consultant. 0 1 2 3 4 N
6. The consultant respected my opinions. 0 1 2 3 4 N
7. The consultant answered my questions. 0 1 2 3 4 N
8. I learned new ways to help children with challenging behaviors. 0 1 2 3 4 N
9. The consultation service positively affected the way I relate to children. 0 1 2 3 4 N
10. Overall, I am satisfied with the consultation service I received. 0 1 2 3 4 N
11. I feel the referring situation has improved. 0 1 2 3 4 N
12. What is ONE thing you're doing differently because of the consultation service you received? (Write on back if needed)

13. Would you recommend this consultation service to other childcare providers? Why or why not?

14. How can this consultation service be improved?

15. Other comments:

OPTIONAL Consultant's Name: ____

OPTIONAL Your Name: ____