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|  | **Tennessee Department of Human Services****SSBG Annual Program Evaluation** |

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| **Contract Information** |
| Agency |       | Federal Fiscal Year |       |
| SSBG Program |  [ ]  Homemaker | [ ]  Adult Day Care |
| Counties Served |       |
| Federal Grant Award | $      | Grant Funds Expended | $      |
| Notes:       |

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| **Service Information** |
| **For October 1 – September 30:** | **Total Clients** | **Total Units** |
| Proposed |       |       |
| Actual |       |       |

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| **Client Goal Achievement** |
| Many programs deal with more than one goal. Agencies are required to address the above items with respect to each goal established for all customers. |
| Goals Achieved: | #      |      % | # Goals Unmet: | #      |      % |
| 1. Please provide the most common reasons clients did not meet their stated goals. Were there any unexpected problems or concerns encountered during the year? Were you able to successfully overcome these problems?
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|       |
| 1. Propose solutions:
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|       |

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| **Terminations** |
| **Reasons** | **Percentage of all Terminations** |
| Client has adequate care from other sources |  |
| Client refuses services |  |
| Client refuses care from appropriate, qualified staff |  |
| Client is self-sufficient and goals in the service plan have been achieved |  |
| No services are provided in over thirty (30) days |  |
| APS requires closure |  |
| Client’s home is unsafe for personal support assistant (PSA) |  |
| Inappropriate behavior including cursing or disrespect toward staff |  |
| Physical, sexual, or verbal violence toward staff |  |
| Adult day services fee not paid |  |
| Client moves out of area |  |
| Client cannot be located |  |
| Provider declines to provide services |  |
| Client moves to a Long-Term Care Facility (LTCF) |  |
| Client is deceased |  |
|  | **Total 100%** |

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| **Personnel** |
| 1. Discuss any major changes in program personnel during the contract period (number, full/part-time, average length of time with agency, promotions/awards, etc.).
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|       |
| 1. Discuss any major changes in board membership and leadership.
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|       |
| 1. Provide a list of training provided for program staff during this contract period.
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| 1. Please describe outstanding staff achievements, awards, and development.
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| **Referrals** |
| 1. Please indicate whether the number of referrals your agency received this contract cycle was an increase or decrease from the previous fiscal year.
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|       |
| 1. Comments regarding increase/decrease
 |
|       |
| 1. What is the average number of units per week each client receives?
 |
|       |
| 1. Has the average number of units per client increased or decreased over the past federal fiscal year?
 |
| Increase [ ]   | Decrease [ ]  | No Change [ ]  |
| 1. Please describe the reasons for the increase or decrease.
 |
|       |
| 1. Please indicate the number of referrals by county
 |
| **County(ies) Served** | **Number of Referrals** |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
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| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| **TOTAL** |  |

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| **Wait Lists** |
| **County** | **Number on Wait List as of 9/30** |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
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| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| Choose an item. |  |
| **TOTAL** |  |
|  |
| 1. If it was necessary to place ***APS clients*** on a waiting list, what was the average wait time?
 |
| Days before receiving services | **Percent of Clients** |
| 0-30 days |       |
| 31-60 days |       |
| 61-90 days |       |
| 91-120 days |       |
| >120 days |       |
|  | **Total 100%** |
| 1. If it was necessary to place ***non-APS clients*** on a waiting list, what was the average wait time?
 |
| **Days before receiving services** | **Percent of Clients** |
| 0-30 days |       |
| 31-60 days |       |
| 61-90 days |       |
| 91-120 days |       |
| >120 days |       |
|  | **Total 100%** |

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| **Client Base** |
| 1. Describe general client base (age, gender, disability, length of time in your program, etc.).
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|       |
| 1. Please describe the most common needs your clients share.
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|       |
| 1. Describe any trends/changes in client population.
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|       |
| 1. Are the trends/changes expected to continue?
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|       |

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| **Limited English Proficiency** |
| 1. How many clients with Limited English Proficiency (LEP) were served over the past fiscal year?
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|       |
| 1. Please describe the agency’s process for LEP delivery.
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|       |

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| **Licensure** |
| 1. Were you audited for licensure by the Department of Mental Health and Substance Abuse Services (DMHSAS)?
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|       |
| 1. What were the audit results?
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|       |
| 1. Please provide any comments regarding licensure and auditing.
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| **Types of Service** |
| 1. Please describe the various services provided to clients over the past year.
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|       |
| 1. Have there been any changes in the services/amounts?
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|       |
| 1. Provide any additional comments about your SSBG-funded program and the impact you are having in your service area. You may also attach copies of any brochures, newsletters, newspapers articles and/or pictures related to this program.
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|       |
| 1. Please comment on ways the Tennessee Department of Human Services (TDHS) could be of assistance to you in maintaining/improving the delivery of services (training sessions, informational meetings, on-site technical assistance, etc.).
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| **Community Partnerships** |
| 1. Please list the various community partners and other TDHS/state and federal grants with which the agency has partnered this year (utility companies, other non-profits, Meals on Wheels, etc.).
 |
|       |
| 1. Has community partnership increased or decreased over the past year?
 |
| Increase [ ]   | Decrease [ ]  | No Change [ ]  |
| 1. Please describe the causes for the increase/decrease.
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| Executive Director Signature | Date |