**Family First Transition Act (FFTA) Funds Reimbursement Claiming Invoice Review Checklist (Detailed)**

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| --- |
| **CBC Lead Agency Name:** |
| **CBC Contract Number:** | **Date Received:**  |
| **Date Approved:** | **Date Submitted to ASSC:** |
| **Please send questions pertaining to items within this checklist to:** HQ.OCFW.FFTA.Funds@myflfamilies.com |
| **Minimum Documentation Requirements** |
| **Action Steps*****(If “No” is answered for any of the data elements below, please return the submitted Invoice packet back to the CBC for correction.)*** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **1a.** Date stamp the Invoice as received if the following has occurred ***Note:*** *There may be one or more of the below Reimbursement Forms* (See 1b. – 1e.): | [x]  | [ ]  | [ ]  |  |
| **1b.** Evidence Based Programs (EBPs) Reimbursement Form (OCA FFPEB), with supporting documentation {A separate reimbursement form must be completed for each EBP}; | [ ]  | [ ]  | [ ]  |  |
| **1c.** Trust-Based Relational Intervention Reimbursement Form (OCA FFPEB), with supporting documentation; | [ ]  | [ ]  | [ ]  |  |
| **1d.** Foster Parent Peer Mentor Reimbursement Form (OCA FFPCI), with supporting documentation; | [ ]  | [ ]  | [ ]  |  |
| **1e.** Qualified Residential Treatment Program (QRTP) Reimbursement Form (OCA FFPRS), with supporting documentation {A separate reimbursement form must be completed for each QRTP}. | [ ]  | [ ]  | [ ]  |  |
| **Review Invoice Payment Request** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **2a.** Verify the Provider, Contract Number, Address, FEID, Telephone Number, Contract Year, and Reporting Period been entered on the Invoice *{all data fields must be completed}.* | [ ]  | [ ]  | [ ]  |  |
| **2b.** Verify an Invoice Number has been entered *{this is a random number assigned by the CBC}.*  | [ ]  | [ ]  | [ ]  |  |
| **2c.** Verify an OCA has been entered to support the completed FFTA Categories rows *{For example, if 3 FFTA Category rows are entered, there should be 3 separate OCAs listed.}.*  | [ ]  | [ ]  | [ ]  |  |
| **2d.** For each FFTA Category listed, verify the Approved Budget equals the amount listed on the CBC’s Schedule of Funds. | [ ]  | [ ]  | [ ]  |  |
| **Review Invoice Payment Request*****{continued}*** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **2e.** For each FFTA Category listed, verify the ‘Total Expenditures to Date’ and ‘Budget Remaining’ amounts are correct. ***Note:*** *This may mean that prior submitted Invoice amounts will need to be used in determining if the ‘Total Expenditures to Date’ amount is correct*. {**Approved Budget** **=** ‘Amount this Invoice’ **+** ‘Total Expenditures to Date’ **+** ‘Budget Remaining’} | [ ]  | [ ]  | [ ]  |  |
| **2f.** Verify the ‘Total’ row amounts are correct. | [ ]  | [ ]  | [ ]  |  |
| **2g.** Has the Invoice been signed by the CBC and their position title has been listed. | [ ]  | [ ]  | [ ]  |  |
| **2h.** If the ‘Budget Remaining’ reflects a negative amount, then reduce the amount listed in the ‘Amount this Invoice’ column by the negative amount. Please return to the CBC to make the necessary corrections. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Evidence Based Programs (EBPs) Reimbursement Form and Supporting Documentation** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **If the reimbursement request is comprised of more than one items and ‘No’ is answered for one or more of these items, please provide a detailed comment indicating which item(s) of the reimbursement request is/are ineligible for reimbursement. A portion of the reimbursement request may still be eligible for payment if the other items listed meet all the requirements below.** |
| **3a.** Verify Section I: General Information has been fully completed. | [ ]  | [ ]  | [ ]  |  |
| **3b**. Verify the EBP(s) is/are rated and approved by the federal Title IV-E Prevention Services Clearinghouse and is/are identified in the state’s five-year Title IV-E Prevention Program Plan, which include: Healthy Families America (HFA); Nurse Family Partnership (NFP); Parents as Teachers (PAT); Homebuilders – Intensive Family Preservation and Reunification Services; Parent-Child Interaction Therapy (PCIT); Brief Strategic Family Therapy; Functional Family Therapy; Multisystemic Therapy; and Motivational Interviewing (MI). | [ ]  | [ ]  | [ ]  |  |
| **3c.** Verify the ‘Date of expense’ entered is the date listed on the receipt provided for each itemized expense. **For example**, if multiple dates are listed for an expense row, then there should be an itemized Invoice, along with a receipt to validate the payment has been made to the provider. which matches each date. **Note:** If the proof of payment, via a copy of the receipt or cleared check, is not received, then this amount is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **3d.** Verify the date of the payment’s receipt is **on or after July 1 of the state fiscal year the funding has been provided for.****Note:** If the date is before July 1 of the state fiscal year the funding has been provided for, the payment is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Evidence Based Programs (EBPs) Reimbursement Form and Supporting Documentation****{continued}** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **3e.** Verify proof of payment. **For example**, the Provider Invoice indicates *“Payment has been received”* **and** the receipt reflects a $0.00 balance due, **or** the CBC’s check has been fully processed and paid by the bank. | [ ]  | [ ]  | [ ]  |  |
| **3f.** Verify that a detailed copy of the contract is provided by the CBC if the reimbursement is due to the EBP being delivered by a subcontracted provider. If staff costs are included, then a list of the staff and their roles must be provided. | [ ]  | [ ]  | [ ]  |  |
| **3g.** If training was provided, verify the list of individuals trained are included in the supporting documentation. If the amount being requested is for the conclusion of the training, training certificates should be provided for those individuals trained. | [ ]  | [ ]  | [ ]  |  |
| **3h.** If reimbursement request is for staff salaries, a list of the staff and their roles, along with a copy of the past payroll(s) being reimbursed must be provided. | [ ]  | [ ]  | [ ]  |  |
| **3i.** If startup costs are being included in the reimbursement request, there should be a listing of the staff and their roles, who are directly benefitting from the startup costs, along with the itemized cost and proof of payment (receipt) are included. **For example**, if reimbursement is for computers, then a list of the staff and their roles who are receiving the computers must also be included in the reimbursement request. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Trust-Based Relational Intervention Reimbursement Form and Supporting Documentation** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **If the reimbursement request is comprised of more than one items and ‘No’ is answered for one or more of these items, please provide a detailed comment indicating which item(s) of the reimbursement request is/are ineligible for reimbursement. A portion of the reimbursement request may still be eligible for payment if the other items listed meet all the requirements below.** |
| **4a.** Verify Section I: General Information has been fully completed. | [ ]  | [ ]  | [ ]  |  |
| **4b.** Verify the ‘Date of expense’ entered is the date listed on the receipt provided for each itemized expense. **For example**, if multiple dates are listed for an expense row, then there should be an itemized Invoice, along with a receipt to validate the payment has been made to the provider. which matches each date. **Note:** If the proof of payment, via a copy of the receipt or cleared check, is not received, then this amount is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **4c.** Verify the date of the payment’s receipt is **on or after July 1 of the state fiscal year the funding has been provided for.****Note:** If the date is before July 1 of the state fiscal year the funding has been provided for, the payment is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Trust-Based Relational Intervention Reimbursement Form and Supporting Documentation*****{continued}*** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **4d.** Verify proof of payment. **For example**, the Provider Invoice indicates *“Payment has been received”* **and** the receipt reflects a $0.00 balance due, **or** the CBC’s check has been fully processed and paid by the bank. | [ ]  | [ ]  | [ ]  |  |
| **4e.** Verify that a detailed copy of the contract is provided by the CBC if the reimbursement is due to the EBP being delivered by a subcontracted provider. If staff costs are included, then a list of the staff and their roles must be provided. | [ ]  | [ ]  | [ ]  |  |
| **4f.** If training was provided, verify the list of individuals trained are included in the supporting documentation. If the amount being requested is for the conclusion of the training, training certificates should be provided for those individuals trained. | [ ]  | [ ]  | [ ]  |  |
| **4g.** If reimbursement request is for staff salaries, a list of the staff and their roles, along with a copy of the past payroll(s) being reimbursed must be provided. | [ ]  | [ ]  | [ ]  |  |
| **4h.** If startup costs are being included in the reimbursement request, there should be a listing of the staff and their roles, who are directly benefitting from the startup costs, along with the itemized cost and proof of payment (receipt) are included. **For example**, if reimbursement is for computers, then a list of the staff and their roles who are receiving the computers must also be included in the reimbursement request. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Foster Parent Peer Mentor Reimbursement Form and Supporting Documentation** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **If the reimbursement request is comprised of more than one items and ‘No’ is answered for one or more of these items, please provide a detailed comment indicating which item(s) of the reimbursement request is/are ineligible for reimbursement. A portion of the reimbursement request may still be eligible for payment if the other items listed meet all the requirements below.** |
| **5a.** Verify Section I: General Information has been fully completed. | [ ]  | [ ]  | [ ]  |  |
| **5b.** Verify the ‘Date of expense’ entered is the date listed on the receipt provided for each itemized expense. **For example**, if multiple dates are listed for an expense row, then there should be an itemized Invoice, along with a receipt to validate the payment has been made to the provider. which matches each date. **Note:** If the proof of payment, via a copy of the receipt or cleared check, is not received, then this amount is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **5c.** Verify the date of the payment’s receipt is **on or after July 1 of the state fiscal year the funding has been provided for.****Note:** If the date is before July 1 of the state fiscal year the funding has been provided for, the payment is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Foster Parent Peer Mentor Reimbursement Form and Supporting Documentation*****{continued}*** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **5d.** Verify the First and Last Name of the Foster Parent Mentor, the Foster Parent Mentor’s FSFN Provider ID, and the Description of expense are listed for each reimbursement request line. | [ ]  | [ ]  | [ ]  |  |
| **5e.** A copy of the training certificate for TRBI or Core Teen Training for peer foster parent has been included. | [ ]  | [ ]  | [ ]  |  |
| **5f.** Using the FSFN Provider ID, verify of that the peer foster parent is in “good standing”, meaning there have been no verified abuse reports within the last 5 years documented in FSFN. *{Checking the ‘Yes’ box indicates there have been no verified abuse reports within the last 5 years.}* | [ ]  | [ ]  | [ ]  |  |
| **5g.** Verify proof of payment. **For example**, the Provider Invoice indicates *“Payment has been received”* **and** the receipt reflects a $0.00 balance due **or** the CBC’s check has been fully processed and paid by the bank. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Qualified Residential Treatment Program (QRTP) Reimbursement Form and Supporting Documentation** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **If the reimbursement request is comprised of more than one items and ‘No’ is answered for one or more of these items, please provide a detailed comment indicating which item(s) of the reimbursement request is/are ineligible for reimbursement. A portion of the reimbursement request may still be eligible for payment if the other items listed meet all the requirements below.** |
| **6a.** Verify Section I: General Information has been fully completed. | [ ]  | [ ]  | [ ]  |  |
| **6b.** Verify the ‘Date of expense’ entered is the date listed on the receipt provided for each itemized expense. **For example**, if multiple dates are listed for an expense row, then there should be an itemized Invoice, along with a receipt to validate the payment has been made to the provider. which matches each date. **Note:** If the proof of payment, via a copy of the receipt or cleared check, is not received, then this amount is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **6c.** Verify the date of the payment’s receipt is **on or after July 1 of the state fiscal year the funding has been provided for.****Note:** If the date is before July 1 of the state fiscal year the funding has been provided for, the payment is ineligible for reimbursement. | [ ]  | [ ]  | [ ]  |  |
| **6d.** Verify proof of payment. **For example**, the Provider Invoice indicates *“Payment has been received”* **and** the receipt reflects a $0.00 balance due, **or** the CBC’s check has been fully processed and paid by the bank. | [ ]  | [ ]  | [ ]  |  |
| **6e.** If reimbursement request is for an addition and/or modification of the physical structure of the facility, there should be at least a quote from two or more providers also provided. | [ ]  | [ ]  | [ ]  |  |
| **Review of the Qualified Residential Treatment Program (QRTP) Reimbursement Form and Supporting Documentation*****{continued}*** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **6f.** If training was provided, verify the list of individuals trained are included in the supporting documentation. If the amount being requested is for the conclusion of the training, training certificates should be provided for those individuals trained. | [ ]  | [ ]  | [ ]  |  |
| **6g. *If applicable***, a copy of the contract/working agreement between the CBC and Child Caring Agency (CCA) is included in the supporting documentation. | [ ]  | [ ]  | [ ]  |  |
| **6h.** If a reimbursement request is an item listed as “other”, there should be a brief description for the necessity of the item.  | [ ]  | [ ]  | [ ]  |  |
| *{Intentionally Left Blank}* |
| **FFTA Funding of Programs by OCA(s)**  |
|  **FFPEB – FFPSA Installation of Evidence Based Services:** |
|  Captures the costs associated with the implementation of the Family First Prevention Services Act (FFPSA) through the Families First Transition Act (FFTA). This act supports the used of evidence-based practices to promote the well-being of children, youth, and families to prevent unnecessary foster care placements. For children who do need to enter foster care, the act encourages use of family-based care. Community Based Care (CBC) lead agencies funding includes CBC Installation of Evidence Based Services. Provides one-time funding reimbursement to CBCs to support local implementation of evidence-based prevention services. The prevention services must be rated and approved by the federal Title IV-E Prevention Services Clearinghouse and are identified in the state’s five-year Title IV-E Prevention Program Plan. Funding is also provided to CBCs who attended the Trust-Based Relational Intervention (TBRI) practitioner training. |
| **FFPCI – FFPSA Enhance Florida Foster Care Information Center:** |
| Captures the costs associated with the implementation of the Family First Prevention Services Act (FFPSA) through the Families First Transition Act (FFTA). This act supports the use of evidence-based practices to promote the well-being of children, youth, and families to prevent unnecessary foster care placements. For children who do need to enter foster care, the act encourages use of family-based care. Community Based Care (CBC) lead agencies funding includes expanding the role of the Florida Foster Care Information Center (FFIC) to include working in partnership with CBCs to provide foster parent peer mentoring services and supporting using the Trust-Based Relational Intervention (TBRI) approach. The foster parents will be trained as TBRI practitioners, offering hands-on assistance to individuals interested in becoming a licensed foster parent as well as existing foster parents caring for children with challenging behaviors. TBRI is an evidence-based service, designed for parents and/or caregivers of children between the ages of 0 -17 years old who have experienced adversity, early harm, toxic stress, and/or trauma. At a minimum, each CBC will receive an allocation of funds to support at least one foster parent peer mentor. |
|  **FFPRS – FFPSA Residential Settings Transition Support:** |
|  Captures the costs associated with the implementation of the Family First Prevention Services Act (FFPSA) through the Families First Transition Act (FFTA). This act supports the used of evidence-based practices to promote the well-being of children, youth, and families to prevent unnecessary foster care placements. For children who do need to enter foster care, the act encourages use of family-based care. Community Based Care (CBC) lead agencies funding includes Residential Settings Transition Support of one-time cost reimbursement funding to residential care providers to ensure the state has appropriate placement capacity for residential treatment programs that meet the new FFPSA Qualified Residential Treatment Program (QRTP) requirements. Funding must be used to meet one or more of federal requirements for QRTPs or state licensure requirements specific to the QRTP program. The Department will confirm that QRTP provider(s) within the CBC geographical service area has successfully obtained or is actively working towards obtaining a QRTP credential. |
| **Submission for Payment**  |
| **Finalizing the Process** | **Yes** | **No** | **Not Applicable** | **Comments** |
| Five-line stamp the FFTA Funds Reimbursement Claiming Invoice, then sign and date to approve payment. | [ ]  | [ ]  | [ ]  |  |
| Prepare Summary of Contractual Services Agreement/Purchase Order form located on the Florida Accountability Contract Tracking System at: <https://facts.fldfs.com/Search/ContractualAgreement.aspx?AgencyID=600000&ContractID=>Once at this website location, enter the CBC Lead Agency’s contract number after the = of the website address. | [ ]  | [ ]  | [ ]  |  |
| **Scan** all completed Invoice documentation with signatures to create an electronic file. | [ ]  | [ ]  | [ ]  |       |
| **Remove** any passwords from the files, documents, and/or spreadsheets. | [ ]  | [ ]  | [ ]  |  |
| *{Intentionally Left Blank}* |
| **Finalizing the Process****{continued}** | **Yes** | **No** | **Not Applicable** | **Comments** |
| **ALL files are to be emailed to:** HQ.FSS.Contract.Invoices@myflfamilies.com **With the following email addresses copied:** HQW.CFO.CBC.ME.Accountability@myflfamilies.com HQ.OCFW.FFTA.Funds@myflfamilies.com  Amy.Kelly@myflfamilies.com  **And the Subject line of the email should be:****FFTA Funds Reimbursement Claiming Invoice for *{Insert CBC Lead Agency Name & Contract Number}*** Monthly –1. Family First Transition Act Funds Cost Reimbursement Invoice (Scanned with original signature and approvals)
2. Evidence Based Programs (EBPs) Reimbursement Form, along with supporting documentation. (Scanned and/or original electronic file)
3. Trust-Based Relational Intervention Reimbursement Form, along with supporting documentation. (Scanned and/or original electronic file)
4. Foster Parent Peer Mentor Reimbursement Form, along with supporting documentation. (Scanned and/or original electronic file)
5. Qualified Residential Treatment Program (QRTP) Reimbursement Form, along with supporting documentation. (Scanned and/or original electronic file)
6. Completed FFTA Funds Reimbursement Claiming Invoice Review Checklist (Electronically signed or scanned with signature)
 | [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] .[ ]  |  |

 Comments:

