NATIONAL ASSOCIATION OF PRETRIAL SERVICES AGENCIES

ACCREDITATION MANUAL:

NAVIGATING THE FIVE STAGES OF ACCREDITATION

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The NAPSA Accreditation materials are a result of hard work and dedication by the Accreditation Committee. NAPSA would like to acknowledge their gifts of time and attention in creating these documents which will guide our initial efforts in the accreditation of pretrial services programs across the country. Thank you.

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Table of Contents

Introduction

National Association of Pretrial Services Accreditation Manual: Navigating the Five Stages of Accreditation was developed to provide guidance for individuals selected to provide auditing services for the National Association of Pretrial Services Agencies (NAPSA) Accreditation program. The manual is part of a series of documents developed to form the foundation for the program's work with pretrial services programs desiring to become accredited under NAPSA standards.

The documents in the NAPSA Accreditation series are the product of a committee of dedicated pretrial professionals, in partnership with the Pretrial Justice Institute and supported through a grant from the US Department of Justice Bureau of Justice Assistance.

For other accreditation documents, see *Standards Checklist* and *Accreditation Auditor's Reference Manual*.

Overview of NAPSA

The National Association of Pretrial Services Agencies, NAPSA, is the national professional association for the pretrial release and pretrial diversion fields. Incorporated in 1973 in the District of Columbia as a not-for-profit corporation, the goals of the Association are expressed succinctly in Article II of its Articles of Incorporation:

- to serve as a national forum for ideas and issues in the area of pretrial services;
- to promote the establishment of agencies to provide such services;
- to encourage responsibility among its members;
- to promote research and development in the field;
- to establish a mechanism for exchange of information; and
- to increase professional competence through the development of professional standards and education.

NAPSA consists primarily of pretrial release and pretrial diversion practitioners; however, others interested in pretrial issues such as judges, lawyers, researchers, and prosecutors, comprise its membership.

Overview of the NAPSA Standards

Policymakers and practitioners concerned about criminal justice issues have increasingly come to recognize the importance of sound "front-end" decision-making. The actions taken in the initial stages of any criminal case—in particular, the decisions concerning the release or detention of an arrested person, and the decision to divert the case from traditional prosecution—can have an enormous bearing on the outcome of an individual case and, in the aggregate, on the quality and effectiveness of the jurisdiction's criminal justice processes. The stakes involved are high: they involve considerations of individual liberty, public safety, and the integrity of the judicial process.

More than twenty-five years ago, the National Association of Pretrial Services Agencies (NAPSA) undertook the drafting of a pioneering set of Performance Standards and Goals for Pretrial Release and for Pretrial Diversion. The original NAPSA Release Standards, published in 1978, sought to define realistically achievable goals and sound pretrial release practices, drawing on the experience of practitioners who had been involved in the first two decades of bail reform efforts in the United States beginning with the Manhattan Bail Project in the early 1960s. The 1978 Standards survived the test of time very well. They were influential in shaping system improvement efforts in a number of states and they provided practical guidance in day-to-day operations for pretrial services program administrators and staff for over two decades.

The soundness of the original Standards was emphasized by the work of a NAPSA committee that examined them comprehensively in the 1990s. That committee recognized the need to revise and update the Standards, but decided as an interim measure to have the original Standards re-issued in 1998, with minimal editing, as the Second Edition of NAPSA's Release Standards.

In 2002, the NAPSA Board of Directors decided that it was time to undertake a fresh re-examination of the original Standards, to take account of emerging issues facing pretrial decision-makers and changes that had taken place in practices, technology, case law, and program capabilities since the original Standards were published. A new Release Standards Committee was formed, with members drawn from pretrial services programs in different areas of the country. The new committee was

charged with reviewing the original Standards, proposing a new set of Standards, and drafting commentary to accompany them.

These Standards, revised and approved by the NAPSA Board in 2004, are intended to provide direction, guidance, and inspiration to pretrial practitioners in their daily work of providing pretrial services in criminal cases. Just as important, these standards serve as a catalyst for change when criminal justice policymakers ask "How do we fashion a criminal justice system that is just, fair, and sound?" Accreditation is one way one way to ensure that these standards are implemented to the fullest extent. An informed, reasoned, honest, and impartial response at the front end of the criminal justice system will resonate throughout the system and will improve the public's trust and confidence in how we deliver justice in this country.

Overview of the NAPSA Commission on Accreditation

Since 2005, NAPSA has realized that pretrial programs across the country would benefit from a nationwide accreditation process. This process was outlined in a strategic plan, described as The Road Map, which was produced with technical assistance from NIC. Similarly, in 2007, at a strategic planning meeting in Florida, the need for accreditation was again listed as a top priority of the Association. Toward that end, an initial meeting was held in July 2009 during which the nucleus and outline of an Association process was described along with a goal of producing a description of the program.

The NAPSA Commission on Accreditation was established in 2011 with the dual purpose of espousing comprehensive, national standards for Pretrial Release and the national standards for Diversion, and implementing a voluntary program of accreditation to measure compliance with those standards.

The Commission was developed as part of the National Association of Pretrial Services Agencies, and is composed of a board which meets yearly. The responsibility of rendering accreditation decisions rests solely with the Commission. The members of the Commission represent the full range of Pretrial Release and Diversion programs.

NAPSA Accreditation Staff

Accreditation activities are supported by the staff of the NAPSA Accreditation Office under the leadership of the NAPSA Education Chair or Accreditation Director as appointed by the NAPSA Board of Directors. Accreditation Office staff are responsible for the daily operation of the accreditation program. Agencies in the accreditation process have contact primarily with the accreditation specialist responsible for their state or program.

NAPSA Accreditation Auditors

NAPSA Accreditation Auditors are selected, trained, and employed on a contract basis by the Association. These individuals perform the field work for the Association which includes providing assistance to programs working toward accreditation, conducting on-site audits of agencies to assess compliance with standards and confirming that requirements are met, and ongoing monitoring to ensure maintenance of the conditions required for accreditation. Teams of auditors, referred to as visiting committees or audit teams, and are formed to conduct standards compliance audits of agencies seeking accreditation and re-accreditations.

Auditors are recruited nationally by Accreditation Office. Affirmative action and equal employment opportunity requirements and guidelines are followed in the recruitment of auditors. All auditors employed by the Association have a minimum of three years of responsible management experience, have received a recommendation from a program administrator, have demonstrated knowledge in the field, completed the NIC program assessment training, are individual members of NAPSA in good standing, and have attained Certified Pretrial Professional status through the NAPSA Certification Program.

NAPSA Accreditation Benefits

The process of accreditation is time-consuming and requires both effort and commitment from program staff. The benefits to a program are proportionate to the program's commitment to incorporate the process into its daily management and operation. It is not just achieving accreditation, but also maintaining accreditation that attests to the program striving for excellence through application of the standards and best practices throughout its operation. Some of the benefits include:

- ***Improved Staff Training and Development.***
  NAPSA accreditation requires a written policy and procedures that establish a training and staff development program for personnel working in the division that is being audited for accreditation. The training requirements address all pre-service, in-service and specialized training curricula with applicable timelines, program's mission, and populations. The professional growth of employees is systematically developed through such training plans that identify job-related training needs in relation to position requirements, current best practices, environmental and legal issues, new theories, techniques and technologies.

- ***Assessment of Program Strengths and Weaknesses***
  A NAPSA accreditation audit assesses: personnel, organizational management, service delivery, use of standards, program elements, and the establishment of objective criteria.

- ***Defense against Outside Interests.***
  Accredited agencies have a stronger defense against attack by the bail bond industry, negative legislation and litigation through the documentation and demonstration of a research-based, impartial program that presents information to judges, thus presenting the most appropriate pretrial release conditions. Toward that end, program personnel become knowledgeable about the standards and best practices that the program must follow.

- ***Establishment of Measurable Criteria for Upgrading Operations.***
  Through the standards and accreditation process, programs continuously review program policy and procedures, and have the ability to make necessary improvements when deficiencies are recognized.

- ***Improved Staff Morale and Professionalism.***
  Accreditation is granted to those programs achieving the highest standard in the field of pretrial services. Staff in Accredited Programs has a better understanding of policies and procedures, this contributing to improved working conditions.

- ***More Constructive Environment for Staff***.
  Administrative and line staff, as well as defendants, benefit from increased program accountability, attention to environmental issues and procedures. The accreditation process ensures a clear assessment of strengths and weaknesses.

- ***Performance-Based Benefits.***
  Performance-based standards provide data that can be used in the day-to-day management of programs. Such data can be used to justify requests for additional funding, defend program practices and justify changes or additions to services. They help policymakers and the public become more aware of the work of pretrial services and the standards to which pretrial agencies aspire.

- ***Strength through the Audit Process.***
  NAPSA Auditors are experienced professionals who are credentialed by the Accreditation Office and approved by the Board of Directors. The average auditor has worked in pretrial for more than 5 years with experience supervising and evaluating the type of programs being reviewed for accreditation. Auditors are also utilized for field consultation, re-audits, monitoring visits and tech support. This oversight keeps the program focused.

Overview of the Accreditation Standards

Each standard has a weight of mandatory or non-mandatory, which is used in determining compliance levels. Mandatory standards address core conditions or best practices. One hundred percent of the applicable mandatory standards must be met for a program to become accredited. However, if a program is not completely in compliance with one of the mandatory standards, it may substitute a "plan of action" outlining how the program will come into compliance by the end of the three-year accreditation period. Re-accreditation will not be granted unless the program has attained full compliance.

Agencies must also meet all but one applicable non-mandatory standard, or have an active plan to implement during the initial period of Accreditation as well as any other criteria stipulated in the policies and procedures of the Accreditation Office.

For every standard, the NAPSA Accreditation Office team that is auditing the program must reach a conclusion about applicability, compliance, or a plan of action. The program must meet every element of the standard in order to be considered in compliance. Most standards require evidence of written policy and procedure and documentation demonstrating implementation of the standard consistent with the policy and procedure.

Overview of the Accreditation Process

The process of accreditation normally takes twelve to eighteen months to complete, and, once attained, is granted for a period of three years. It encompasses five stages: the Applicant Status; the Correspondent Status; the Candidate Status; the Accredited Status; and Re-Accreditation. Maintaining continuous accreditation and integrating the standards into the day-to-day operations of the program is an ongoing task. Regardless of the type of program involved, the process remains constant. The basic timelines, requirements, and outcomes of the process are the same for federal, state or county or non-profit programs. All programs sign a contract, pay fees, prepare a self-evaluation report, and are audited by independent, pretrial professionals who are trained auditors. A panel of the NAPSA Accreditation Commission makes final accreditation decisions.

How This Document is Organized

This document is laid out according to the five stages a pretrial release or diversion program must go through to achieve and maintain accreditation.

STAGE ONE: THE APPLICANT STATUS

Eligibility Criteria

The first step in the application process is to determine eligibility. The following conditions must be satisfied prior to a program's acceptance into the accreditation process:

- ❖❖ the program is part of a governmental entity or conforms to the applicable federal, state, and local laws and regulations regarding corporate existence;
- ❖❖ the program works with pre-trial or pre-sentenced adults or juveniles who are being held pending a hearing for unlawful activity;
- ❖❖ the program has a single administrative officer responsible for program operations.

Compiling Application Materials

Interested pretrial release or diversion programs that believe they are eligible should contact the NAPSA Accreditation Office to explore the possibility of applying for accreditation. A NAPSA accreditation specialist will assure that the eligibility criteria are met. The Accreditation Office will then provide the program with the following application materials, which must be submitted to begin the application process:

- ❖❖ informational material about the standards and the process, including this policy-and-procedure manual, and the manual of standards for the program, and appropriate NAPSA standards
- ❖❖ a blank Organization Summary template used to provide descriptive information about the program (see Appendix B)
- ❖❖ a contract, which sets out tasks and responsibilities of the program and the Association, and fee schedules

Responsibilities of the Program and the Association

Each pretrial program must provide required information about itself. This covers program organization; compliance to standards; program operations, policies and procedures; and areas where the program is working toward compliance. Further, the Accreditation Office requires that agencies post notices of the approaching standards compliance audit, inviting submission of written comments and information about the program from staff and other interested individuals. The Accreditation Office will provide posters to the program for this purpose (Appendix A).

When the Accreditation Office receives any of the above information, data, and correspondence about a specific program, copies of relevant correspondence and responses are placed in the program's file. The Accreditation Office also requires that a program provide news articles, special reports, and/or other information that might impact upon accreditation. Copies of the other information (news articles, court orders) are useful to the audit team members for review before the visit to the program. The auditors may meet with these individuals and, possibly other agencies and judges in the court.

While working to increase openness and accountability for the process, the Accreditation Office maintains strict requirements for protecting the confidentiality of agencies in the process. In speaking with media and others from outside the program, the Office provides information only about the process and standards application for a particular program or institution. This includes an explanation of the requirements of the self-evaluation process, audit policies and procedures, dates and activities of

the audit, the reporting process following the conclusion of the audit, the role of the audit team, and the hearing process.

When a program is aware of media interest, or coverage of a program in the process, Accreditation Office staff must be contacted and kept informed of events. If a program has invited media representatives or other parties to participate in an audit, Accreditation Office staff, audit team members, and program personnel should discuss protocol for such participation in advance. In most cases, others outside the program will serve only as observers.

The Office does not disclose to external parties specific information contained in the program's self-evaluation report, audit team report, or information discussed in the hearing. It is up to participating agencies to provide any information to interested parties about their accreditation activities, including disclosure of the self-evaluation and visiting committee reports.

Fees

Fees are determined during the application stage and are included in the contract signed by the program and the Association. As delineated in the contract, the fees cover all services normally provided to a program by the Accreditation Office staff, auditors, and the NAPSA Accreditation Commission ("Commission"). The costs of orientation training, field consultation visits, and monitoring visits if required, are in addition to the basic fees, at a rate of cost plus 25%. The balance of the contract must be paid in full in order to receive a certificate of accreditation after the accreditation hearings.

Program Withdrawal

A program that no longer wishes to pursue accreditation may formally withdraw from the process through formal notification in writing to the Accreditation Office. The program may wish to withdraw because of turnover in administration or staff, inadequate funds to bring the program into compliance with the standards, or a change in program mission. Fees already paid to the Association are not refundable.

STAGE TWO: THE CORRESPONDENT STATUS

The process formally begins when the program returns both the completed Organization Summary and the signed contract. The Accreditation office notifies the program in writing of its acceptance into the process within 30 days of receipt of the necessary application materials. Once notified, the program becomes a "Correspondent," and an accreditation specialist is assigned as a liaison to the program. The accreditation specialist is responsible for maintaining contact with the program, providing assistance, and monitoring its progress. The program may request assistance through the accreditation specialist at any time in order to clarify standards and requirements.

During this stage the program administrator appoints an accreditation coordinator, who then lays the groundwork for the accreditation audit.

The Accreditation Coordinator

It is essential that the program commits the necessary time and resources to the process. This includes assignment of an accreditation coordinator who has the full cooperation and support of the program administrator. The accreditation coordinator is responsible for the following:

- serving as the program's primary contact with the Accreditation Office
- serving as the program's coordinator of all accreditation activities
- maintaining an internal information exchange to ensure that program staff are provided with timely responses to inquiries about the standards and the process
- arranging and coordinating visits to the program by auditors for technical assistance, standards compliance audits, re-audits, and monitoring visits
- preparing and submitting correspondence and reports to the Accreditation Office within designated time frames, including final organization and preparation of a self-evaluation report, the program's responses to the audit team report, annual certification reports, and other documents requested
- representing the program at the accreditation hearing
- providing input in the development and revision of accreditation policies and procedures and the standards, when requested by the Accreditation Office.

Agencies that have several programs in the process may also have an accreditation coordinator in the central office who acts as the liaison between the programs in various departments or sites and the NAPSA accreditation specialist.

During the Correspondent Status Stage, the specific responsibilities of the Accreditation Coordinator include:

- conducting an orientation for program personnel
- developing and implementing a work plan for the accreditation process
- assembling the documentation necessary to prove compliance with each accreditation standards
- conducting a self-evaluation to assess readiness to undergo the accreditation audit
- requesting technical assistance from the Accreditation Office, if necessary, to be ready for the audit
- requesting a mock audit, if desired, to further assess readiness.

The remainder of this section discusses each of these responsibilities.

Orientation for Program Personnel

Each program should have an orientation process for its staff. The introductory orientation session includes an explanation of the purpose, goals, and organization of NAPSA; the accreditation process, the program's reasons for electing to pursue accreditation, and the benefits of accreditation for the program. Time should be provided for the staff to ask questions of the program administrator and the accreditation coordinator.

The training program for those who will directly participate in the accreditation activities should focus on the specific requirements of the program for successfully completing the self-evaluation phase. The curriculum should address the following subjects in detail:

- background and organization of the NAPSA Accreditation standards and best practices
- introduction to the process, including the requirements of Correspondent, Candidate, and Accredited status
- benefits of the process
- program self-evaluation activities, including the organization of resources and staff assignments to the accreditation team and review committee
- procedures and requirements of preparing the self-evaluation report
- documentation requirements and procedures
- audit procedures
- compliance maintenance procedures

The Work Plan

The accreditation coordinator prepares and supervises the implementation of a work plan for accomplishing tasks required to achieve and maintain accreditation. This plan identifies program staff that will be responsible for performing specific tasks and the dates for completing those tasks.

The work plan, developed by the accreditation coordinator and endorsed by the program administrator, should include the following elements:

- identification of program needs and specific tasks and resources required to conduct the self-evaluation and bring the program into compliance with the standards
- staff training, including both the orientation and periodic sessions to communicate Association policies, standards interpretations, and different phases of the process
- communicating accreditation activities
- a schedule for task completion
- a compliance maintenance system for staff to incorporate into the process, including methods for updating documentation and the development of policies, procedures, and regulations
- plans for conducting internal reviews and a mock audit
- a method for collecting data and outcome measures when required.

To implement the work plan, the accreditation coordinator may assemble an accreditation team composed of staff members who will be responsible for determining compliance with specific chapters of the standards manual, compiling documentation, developing policies and procedures, overseeing implementation of the standards, record keeping, and preparing plans of action. The staff selected for the accreditation team should have the ability to make decisions for their respective areas. In addition to these individuals, there should be an internal review committee composed of program staff. The purpose of the committee is to assess the adequacy of the documentation prepared by the team.

The accreditation coordinator develops and maintains a regular meeting and review schedule for staff involved in the process. Meetings are held for staff to report on their progress, review problem areas, and indicate when outside assistance is needed to clarify accreditation policy and procedure. The accreditation coordinator must ensure there is open communication on a regular basis from the program administrator to line staff, stressing support and expectations for the process.

Developing Documentation

In order to substantiate a finding of compliance with a standard, the program must be able to demonstrate to the audit team that it is in compliance with all parts of a standard at all times. This is accomplished through presentation of written documentation, interviews with staff, and observations which clearly demonstrate that the program is meeting the requirements of the standard. It is perhaps the most time consuming and demanding aspect of the process for the program.

Agencies preparing for initial accreditation are held accountable for documenting standards compliance for a minimum of 12 months prior to the audit. Once policy and procedure for a standard has been developed, the program must have documentation to demonstrate continuous compliance from that point in time to the present.

Documentation should directly relate to the standard. It is the standard, not the discussion or comment of the standard, upon which the program is audited and a compliance decision is made.

There are several methods of documenting compliance with the standards:

- written documentation, which includes, but is not limited to, policies, procedures, records, forms, logs, etc.
- interviews with staff,
- observation or sight confirmation

The members of the audit team will depend on all of these when they visit the program to conduct the audit. Verbal reports alone are never sufficient to support compliance.

The Accreditation Office distinguishes between two categories of documentation:

- *Protocols* are the written guidelines specifying what will be done and how it will be accomplished. This is generally provided in program policies and procedures. Expected Practices indicate that the program requires something, but does not prove that something is being done.

- *Process Indicators* are the backup material that demonstrates written policies and procedures have been implemented and are being followed. In order to show compliance with a standard, there must be evidence that what is required is actually being accomplished. This type of documentation is generally drawn from program logs, records, photographs, and routine reports and may be supplemented by sight confirmation and verbal reports, for example.

Some of the standards require outcome measures. Outcome measures are quantifiable (measurable) events, occurrences, conditions, behaviors, or attitudes that demonstrate the extent to which the condition described in the corresponding performance standard has been achieved. Outcome

measures describe the consequences of the organization's activities, rather than describing the activities themselves. Outcome measures will enable administrators and practitioners to monitor activities and to measure the outcomes of their effort over time. Outcome measure data is continuously collected and calculated every 12 months for each year of the audit cycle. Agencies undergoing an initial accreditation will have up to 12 months' worth of the required information available. Agencies being considered for re-accreditation submit a completed Outcome Measure Report to the Accreditation Office with the required annual report for the first two years of the re-accreditation cycle. The completed third year report will be reviewed by the audit team during the facility audit. In any case the outcome measure report will be included as an attachment to the final audit report. This information can be presented in a format selected by the program and approved in advance of the actual NAPSA audit.

Questions related to applicable process indicators supporting compliance should be directed to the Accreditation Office.

Setting up Files

In preparing for a standards compliance audit, documentation is compiled for each standard. A file or binder is created to contain the documentation materials. The materials should be organized in a logical sequence according to the sequence of the standards – one tab for each standard.

Standards Compliance Checklists

For each accreditation standard, there is a standards compliance checklist page that must be included in the front of every standards folder (see Appendix D). Information recorded by the program on the checklist includes:

- determination of compliance, non-compliance, or non-applicability, and
- list of documentation to support compliance, justification for findings of non-applicability, or justification for plan of action, if needed, and.
- signature of the individual(s) responsible for determining compliance and compiling documentation.

The program completes the left side of the checklist for every standard ensuring that all of the required information is provided. Guidelines for conducting the standards assessment, preparing documentation, or submitting waiver requests are contained in later sections of this manual. During the standards compliance audit, audit team members will complete the right side of the checklists and forward the checklists for non-compliant and non-applicable standards to the Accreditation Office staff for inclusion in the visiting committee report.

Expected Practices

It is not necessary to place an entire document or policy in a file. Copies of operational manuals, classification manuals, personnel manuals, or other similar types of manuals do not need to be copied in entirety to support compliance with each and every standard in a particular chapter. Relevant pages of the manual that relate to a specific standard(s) should be placed in the file folder, or these manuals may be referenced and made available for an auditor's inspection. All pertinent paragraphs/sections of a document or policy that are placed in the file should be highlighted for easy reference.

Process Indicators

Standards compliance folders should include one or two good examples of supporting documentation for each year being audited (initial audits require one year; re-accreditation audits require three years). Additional documentation should be readily available for the audit team review upon their request.

Only materials that demonstrate compliance with the standard are included or referenced in the file. Irrelevant or extraneous material that, while related to the standard, does not prove compliance, should not be included.

The documentation files must be kept current. A system for continuous updating should be established and those staff members responsible for compiling files should be responsible for updating them. Documentation is not based on calendar years or fiscal years but rather from audit to audit. For example, a facility undergoing an initial audit in March 2012 must have supporting documentation dating back to March 2011 in most cases. When this same facility pursues re-accreditation and has an audit in March 2015 their supporting documentation should cover the following timeframes:

- Year #1: April 2012 – March 2013
- Year #2: April 2013 – March 2014
- Year #3: April 2014 – March 2015

Non-Applicable Standards

Unless noted in the Standards checklist, or expressly agreed upon by the program and the Accreditation Office in advance, the program applies all sections of the applicable manual. In signing a contract with the Association, the program accepts the standards for application in the process and may not omit individual standards or portions of standards because it does not wish to establish a required program or procedure. There are sections of the Standards checklist, however, that may not apply, depending on the circumstances at the program.

In the above cases, the sections of the Standards checklist indicate when the standards may not apply to the program. For these standards, a statement explaining why the standard does not apply must be provided, and when appropriate, documentation supporting the reason for the finding should be available for review by the audit committee during the standards compliance audit.

Program compliance percentages are calculated based on the number of applicable standards. The number of non-applicable standards is subtracted from the total number of standards that the program is required to meet. The number of standards found in non-compliance is subtracted from the number of standards that are applicable. The number of standards in compliance is divided by the number of standards that are applicable and that equal the percentage of standards in compliance.

The Self-Evaluation Report

The self-evaluation report (self-audit) documents the program's progress through the self-assessment phase of the process. It is prepared by the program's accreditation team and compiled by the accreditation coordinator. The report requires a comparison of program policies and operations with each accreditation standard. Through its preparation, the program identifies specific deficiencies with respect to the standards and develops plans for correcting them. Upon completion of the report, the program has attempted to answer the following questions for every standard:

- Does the standard apply to the program?
- Does the program comply with the standard?

- How can compliance be demonstrated?
- In instances of non-compliance, what does the program need to do to comply with the standard?

With the self-evaluation there is a compliance tally sheet used to indicate the percentage of mandatory and non-mandatory standards in compliance by category. (See Appendix E.) Compliance percentages are calculated by dividing the number of standards in each category with which the program complies by the total number of standards in that category that are applicable. Information contained in the self-evaluation should include the percentage of compliance with mandatory and non-mandatory standards, a list of non-applicable standards and reasons for such, and a list of non-compliant standards and their deficiencies. Upon completion of the self-evaluation, agencies can determine if they meet the minimum threshold for achieving accreditation, compliance with 100% of the mandatory standards (or one mandatory standard action plan), and either compliance with the non-mandatory standards or plan of action with non-mandatory standards that are not in compliance. Agencies that have not met the minimum threshold are not eligible to request a standards compliance audit. The Accreditation Office is the final arbiter of confirmed compliance.

The Accreditation Office requires that a self-evaluation audit be completed by each applicant for initial accreditation. Agencies pursuing re-accreditation have the option of completing the self-evaluation audit and submitting it to the Accreditation Office. The self-evaluation audit is due to NAPSA at least six weeks prior the audit.

Technical Assistance

While preparing for the audit, the program may require clarification of policy and procedure, assistance in determining the applicability of particular standards to their program, or standards interpretations to clarify the meaning and intent of individual standards. When technical assistance or guidance is needed, the accreditation coordinator contacts the program's assigned accreditation specialist at NAPSA to discuss the issue(s). Confusion or uncertainty about policies and procedures often can be alleviated by a telephone conversation. Written confirmation of agreements or decisions made by Accreditation Office staff and the program is appropriate.

In addition to assistance available from staff through an exchange of correspondence, information, and telephone contacts, the Accreditation Office is able to provide on-site assistance to agencies. This is at the request of the program and involves charges to the program in addition to basic fees. The field consultation entails a visit by a staff member or auditor to an individual facility or program. The purpose of the visit is to provide assistance to the program in conducting its self-evaluation and preparing standards compliance documentation. Field consultation visits are encouraged for programs seeking initial accreditation.

At a program's request, the Accreditation Office arranges for an auditor to provide on-site assistance in one or more of the following areas:

- explanation of policy and procedure, including audit preparations
- interpretation of the applicability of standards to specific areas of concern
- evaluation of the appropriateness and thoroughness of documents to support standards compliance

A field consultation visit typically entails a review of selected standards and documentation prepared by the program. During the review, the auditor looks for the appropriate application of standards to the program and addresses organization and completeness of documentation files to ensure that the necessary types of documentation are provided.

The determination of need for an onsite consultation visit is generally made toward the end of the Correspondent period, after the program has started its self-audit. Accreditation Office staff assists the program in assessing the need for a visit. If a visit is agreed upon, the activities and schedule are set. The accreditation audit specialist assigned to the program coordinates the visit. A contract containing information concerning the purpose of the consultation is prepared by the Accreditation Office and sent to the program. Transportation and lodging arrangements are handled in the same fashion as for other Association visits. The cost of the field consultation is in addition to the basic fee and is established at a rate of cost plus 25 percent. Every effort is made by staff to keep the costs of the visit at a minimum.

Although there is an additional charge for a technical assistance visit, the use of an auditor may prove to be cost effective when long-range benefits are considered. If a program requests an audit and does not achieve the necessary minimum compliance levels, the cost of a re-audit can be substantial. In order to maintain the integrity of the process, the individual conducting the field consultation is never assigned to the visiting committee performing the standards compliance audit.

Details of the auditor's findings are included in a written report submitted to the Accreditation Office at the conclusion of the visit. The contents of the report vary according to the program's specific needs; however, the report usually covers the following:

- names and positions of participants
- general and/or specific program deficiencies related to the standards
- organizational problems regarding standards interpretations and/or policy and procedure
- unique aspects of the program or worksite that could affect the outcome of standards compliance audit.

If individual standards are reviewed for compliance, the report reflects these findings. Likewise, the auditor notes any weaknesses with particular aspects of documentation. These items alert Accreditation Office staff and the program to potential problem areas prior to scheduling a standards compliance audit. Upon receipt of the report from the auditor, Accreditation Office staff review the report and forward copies to the program.

Mock Audits

At the program's request, the Accreditation Office can arrange for a full audit team to conduct a *mock audit* to assess the program's readiness for the actual accreditation audit. This is not part of the accreditation fee, but, can be part of a technical assistance contract and conducted prior to the self-evaluation/mock audit. This onsite visit is geared less toward training program staff and more toward assessing compliance with the standards. Transportation and lodging arrangements will be handled in the same manner as other Association visits. In order to assess program readiness, the team will:

- tour the program worksite
- review records, files, and completed standards compliance folders
- interview defendants, staff, and others as appropriate
- prepare a report for the program (see above) of the findings that may include recommendations to facilitate standards compliance

Fees for the mock audit will be calculated at a rate of cost plus 25 percent, and will require a contract. The Accreditation Office will make every attempt to keep the cost to the program at a minimum.

STAGE THREE: CANDIDATE STATUS

When the program's self-evaluation report indicates levels of standards compliance are sufficient for accreditation, the program requests an audit and becomes a "Candidate." Candidate status continues until the program has been visited by the audit team, and has been awarded or denied accreditation by the Accreditation Office.

The program's activities during candidate status focus on preparing for the standards compliance audit, which is an on-site review by a visiting committee composed of a team of trained auditors.

Audit Request and Arrangements

The program's request for an audit must be made at least 90 days in advance of the visit by the audit team. The initial request may be a telephone contact between the accreditation coordinator and the accreditation specialist assigned to the program. The audit is typically scheduled, at the latest, six weeks prior to the next meeting of the Accreditation Office. These dates are established to allow sufficient administrative time for the processing of the audit team report and preparation for the panel hearing. Office panel hearings are scheduled two times a year: April/May, and October/November.

In the 90 days prior to the audit, Accreditation Office staff establishes with the program the dates of the audit, selects and confirms audit team members, clarifies audit activities and standards to be reviewed, and ensures that the necessary information and materials are provided to the program and audit team members. Coordination of audit plans and activities is done through telephone contacts, e-mail, and exchange of correspondence and materials between the program's accreditation coordinator and the Accreditation Office's specialist/auditor.

The accreditation coordinator and Accreditation Office staff work together to make arrangements for the audit. If a postponement to the audit is required, it must be requested, in writing, at least two weeks prior to the scheduled audit. The request must state the reasons for the request, for example, pending approval of funds needed to make changes required to meet the standards in the case of action plans and non-mandatory standards, completion of worksite renovations, or completion of staff training for new employees.

Once plans have been confirmed, the program should contact the audit team members and the Accreditation Office to coordinate travel schedules, local transportation, and lodging. All expenses are paid by the individual auditors, who are in turn reimbursed by the Association. Accreditation Office staff are to be notified *immediately* of cancellations, postponements, or other changes in plans affecting the audit.

Final Program Preparation

To confirm audit arrangements, the Accreditation Office sends the program a letter and materials detailing the audit dates and location(s), names, addresses and telephone numbers of the audit team.

The Accreditation Office also provides posters to the program announcing the purpose and dates of the visit by the audit team. As part of the Association's policy on public information and openness, the Accreditation Office requires that all programs post this public notice of the approaching standards compliance audit in conspicuous locations throughout the office, inviting comments from staff, and others interested in the program. Any relevant comments received by the Accreditation Office are reviewed by the visiting committee during the course of the standards compliance audit.

The Audit Team

The audit team is composed of one or more auditors who have been assigned by the Accreditation Office to conduct the audit. The size and composition of the audit team is determined by Accreditation Office staff and depends on the type and size of the program, number and location of units to be audited, special programs, etc. In selecting audit team members, there is always an effort to select auditors with experience and special knowledge about the type of facility or program to be audited. In order to avoid a potential conflict of interest or its appearance, the audit team will not include any auditors who are, or previously have been, employed by the program being audited, or who are connected to a larger entity with several programs in the state or who receive common funding in the state who works in the same state. Auditors who served as pre-audit auditors for the program are not assigned to the audit team.

An audit team leader is designated to organize and supervise the audit activities. The team leader is the senior representative of the audit team and, as such, is responsible for carrying out the Association's policies and procedures pertaining to standards compliance audits. The team leader's responsibilities include:

- conducting the audit and supervision of the other members of the audit team to ensure consistent and accurate application of policy, procedure, standards interpretation, and professionalism in the overall conduct of the audit
- dividing the standards among team members based on an individuals' areas of expertise
- preparing the audit team report consistent with an established format and guidelines
- submitting the report and any required attachments to the Accreditation Office for dissemination to the program and other members of the visiting committee.

The program is responsible for arranging hotel reservations and local transportation for the audit team. Hotels that offer special government rates should be given priority considerations. The accreditation coordinator also plans for, or provides, transportation for audit team members to and from the airport, hotel, and facility. Each audit team member is contacted for his/her arrival time and informed of the hotel accommodations and transportation arrangements.

The accreditation coordinator ensures that a descriptive narrative of the program and the Standards Checklist is distributed to the audit team members. Information on any lawsuits (case number and cause of action), and judgments against the program must be provided to the team leader. The team leader will incorporate this information into the audit team report for presentation to the Office.

The Compliance Audit

The purpose of the compliance audit is to have the audit team examine the program's policies, procedures, and operations in order to evaluate compliance with the standards based on the documentation provided by the program. *Accreditation is not determined or awarded by the audit team; it is determined by the Commission on Accreditation for NAPSA subsequent to the panel hearing*.

The amount of time required to complete the audit depends on program size, number of applicable standards, different sites or facilities to be visited, etc.

All members of the audit team usually arrive the evening prior to the first day of the audit. On the day of arrival, the audit team leader convenes an organizational meeting during which team members establish a preliminary audit schedule and determine audit assignments. This involves dividing sections of the manual of standards among team members. The Accreditation Office recommends that the accreditation coordinator join the organizational meeting as an introduction to what the program can expect. During

the meeting, the accreditation coordinator briefs the team on the program's expectations, reviews any recent events that may affect the outcome of the audit, and answers questions regarding the materials received.

The audit day will often exceed an eight-hour workday for audit team members, whose work can be greatly facilitated by a well-organized presentation of documentation by the program. While audit team activities vary slightly depending on the type of program being audited, the standards compliance audit includes several basic elements that are needed to verify standards compliance:

- an entrance interview
- an program tour
- a review of standards compliance documentation
- interviews with program staff, defendants, and others
- an exit interview.

Entrance Interview

An entrance interview is usually held the first morning of the audit. In addition to the audit team, those present include the program administrator, accreditation coordinator, and other staff determined by the program administrator. During the entrance interview, team members introduce themselves and provide the program with a brief summary of their backgrounds and credentials. The audit team leader discusses the purpose of the audit, presents a tentative schedule of the team's activities, and responds to any questions that may arise concerning the conduct of the audit. During the entrance interview, the program administrator introduces all key staff members to the auditors. The accreditation coordinator should be available to the audit team at all times during the audit to answer questions, provide additional materials, and serve as a liaison between the program staff and the audit team.

Program Tour

Following the entrance interview, the audit team tours the program workspace. Tours work in conjunction with an in-depth evaluation of written documentation to assist the audit team in assessing compliance for individual standards and through their observations of the program space(s) during the tour.

The length of the tour depends on the size and type of program being audited. When large programs are audited, the team may split up to cover separate areas of the site (s) and other areas. The tour includes all areas of the program, serving mainly to familiarize the auditing team with the layout of the site, such as the location of particular units, offices, and program areas. In addition, the tour allows audit team members to meet department heads, supervisors, and program staff. As they review standards compliance documentation, team members return to different areas of the site to conduct more thorough inspections, observe program operations, and interview staff. If applicable, auditors will also conduct an evening visit in order to acquire a better understanding of the overall operation and programming of the program and to verify through observation documentation reviewed during the day. Program personnel are notified when audit team members intend to return to the worksite during evening hours.

Standards Compliance Review

Audit team members spend much of their time during the audit reviewing the standards and documentation prepared by the program to demonstrate compliance. The audit team reviews selected case files, standards folders, personnel records, and any outcome measures. In addition, interviews with individual staff and clients are conducted as necessary to supplement written evidence of compliance. The program ensures that all appropriate personnel are available to the visiting committee during the audit.

A room is provided where the audit team can work throughout the audit. This room should contain chairs and at least one large table, and should afford privacy and an atmosphere conducive to work. The location of the room should allow ready access to the pretrial services program offices, personnel, and program operations. Files, documentation, and reports that the audit team will need to review should be available in the room.

Each team member reviews designated sections of the accreditation standards checklist and is authorized to independently determine compliance with all non-mandatory standards. The audit team, as a whole, reviews mandatory standards, non-compliance, and non-applicable findings. When there is an issue regarding the compliance of a mandatory standard, the Director of the Accreditation must be contacted. Issues, questions, or standards requiring special consideration are also discussed by all team members and, if necessary, referred to Accreditation Office staff.

It is the program's responsibility to provide the documentation necessary to demonstrate compliance with each standard. In addition, the following principles and guidelines apply for review of documentation by the audit team:

- Process indicators created once the audit has started will not be accepted. It is permissible to provide additional documentation should the audit team request it, but such documentation must already have been in existence when the audit began. Once the audit is concluded, a program cannot bring itself into compliance with a standard for the purpose of changing the compliance tally, unless a re-audit is conducted. Compliance achieved subsequent to an audit is reflected in the program's annual compliance certification review, during monitoring visits, and during reaccreditations.

- Auditors review a random selection of files as stipulated in the Accreditation Standards Checklist to ensure standards are met.

- Documentation for agencies going through the process for the first time must demonstrate:

  √ continuous implementation of policies and procedures that were already in place when the program formally entered into the process and that meet the standard
  √ implementation of policies and procedures that were initiated during Correspondent and Candidate Status from the point of their development (Normally 12 months is required, however when limited time is available to generate supporting documentation for newly-implemented policies and procedures, exceptions may be granted by the Director of Accreditation.)
  √ implementation of new policies and procedures (Normally 12 months is required, however when limited time is available to generate supporting documentation for newly-implemented policies and procedures, exceptions may be granted by the Director of Accreditation)
  √ records that reflect newly-implemented policies, procedures, and forms.

Where local policy and procedure have been developed to meet the standard, the auditors verify the authority of the program to do so. Local policy is usually developed to adapt parent program policy to local needs. Non-compliance is concluded if the local policy or its implementation conflicts with the parent program's policy. Agencies should not assume that decisions rendered for other programs within the same program are necessarily applicable for all programs agency-wide, unless the Accreditation Office has issued a statement to that effect.

The Audit Team's findings for each standard are recorded on the same type standards compliance checklists used by the program in preparing its self-evaluation report. Where collective decisions are required (on mandatory, non-compliance, and non-applicable standards), the concurrence of all audit team members is indicated by signatures on the checklists.

Auditors are trained to interpret standards strictly. If compliance is questionable or a standard is not documented fully, the auditor concludes non-compliance. The program may appeal such findings by the audit team in its response to the team's report and to the Accreditation Office at the time of the hearing. The Commission on Accreditation for NAPSA renders the final compliance decision.

Interviews

Audit team members conduct interviews with all levels of program staff during the audit. The audit team selects the individuals to interview and the issues to discuss in order to obtain verbal confirmation of standards compliance or clarify problems that may surface during reviews of documentation. In addition to the interviews that occur at random, the following guidelines apply in conducting interviews during the audit:

- in auditing large programs all department heads may be interviewed
- others who have sent correspondence to the Accreditation Office may be interviewed
- other individuals who respond to the invitation for comments contained in the posted announcement of the audit also may be interviewed, including an institutional ombudsman, attorneys, representatives of public interest groups, etc.

Exit Interview

At the conclusion of the audit, the Audit Team meets with the program administrator, accreditation coordinator, and appropriate staff to discuss the results of the audit. As with the entrance interview, the program administrator determines the staff and guests who will be present. The audit team reports its results including findings of non-compliant and non-applicable standards, stating the reasons for each decision. Findings reported by the audit team are preliminary with the formal results to be presented in writing in the team's report.

The exit interview is not a forum for debate on the merits of the standards or the audit team's assessment of program documentation. The process for resolving disagreements between the program and the audit team occurs through the program's response to the team's report and at the time of the hearing. All final decisions regarding accreditation rest with the NAPSA Commission on Accreditation.

Audits of Probation Agencies Who House Pretrial

For both adult and juvenile field services programs, the Association visits the program's central office and/or regional office and a sampling of field offices within the system. Association policy requires that no less than 20 percent of the individual field offices are visited during the standards compliance audit. Individual field offices to be audited are selected by the staff in consultation with the accreditation manager at the time the standards compliance audit is requested. Field offices are selected on the basis of their geographic location, number of staff, and caseloads. Efforts are made to audit a representative sample of field service offices. Transportation to and from the field offices is the responsibility of the program.

Documentation requirements for multi-office programs are the same for individual programs; however, audit activities vary slightly. During standards compliance audits of field service agencies, visiting committee members convene at the program's central office on the first day of the audit and review all of the applicable standards. During the remainder of the audit, the audit team members separate to visit individual field offices.

Emphasis in multi-offices of programs is placed on review of standards that reflect implementation of program policies and procedures, including those standards that address case record maintenance, field supervision, caseload management, etc. Staff interviews also are conducted to support documentation review. *Since the accreditation of a field service program is system-wide, a non-compliance finding at one office applies to the entire system.* Following the audits of individual field offices, audit-team members return to the central office for the exit interview.

Central Office Review of System-wide Policies and Procedures

Programs with a number of offices and programs involved in the process may choose to have the Audit Team visit the central office before scheduling audits of individual programs or sites. The central office review provides a review of system-wide policies and procedures issued by the program for implementation in local facilities and programs. The central office review is intended to:

- assist the central office in identifying non-compliant areas as a result of system-wide policies
- reduce documentation requirements for individual sites and programs that are being audited under the same manual of standards
- enable audit teams at each facility to spend less time with paperwork and more time addressing program operations, touring the program, and interviewing staff, and others

Accreditation Office staff work with the program administrator in determining the need for such a visit, and in identifying standards for review by the visiting committee. Arrangements for the review are made through Accreditation Office staff, and involve confirmation of the audit dates, auditors, applicable standards, and other necessary information.

The central office review is conducted in the same manner as other standards compliance audits, focusing specifically on a review of central office policies and procedures to determine compliance with standards that correspond to the type of programs administered by the program. Compliance review techniques remain the same as for standards compliance audit with an emphasis on reviewing expected practices. Interviews with program staff are held primarily to clarify policies and standards documentation. No tour is required.

The central office review results in identification of specific standards, referred to as generic standards, for which the finding of compliance, non-compliance, or non-applicable is the same for the worksite and all of their programs. Also included in this category are those standards that the program may be able to demonstrate system-wide compliance through presentation of expected practices and process indicators. These standards then require review only at the central office and findings automatically apply for all sites or programs.

If there are extenuating circumstances that make one site different from the other sites, that site will need to present relevant local policy and process indicators to demonstrate implementation. They are required to have a folder with a standards compliance checklist and a copy of the letter from the Director of Accreditation that grants compliance as a result of the central office review.

A report is prepared following the central office visit. The report identifies generic standards with which the program and its programs are found in compliance, non-compliance, or are non-applicable, based solely on system-wide policy, procedure, and standards requirements. The report also specifies problems or deficiencies that result in non-compliance. These standards do not require further review, and the individual facilities or programs should be instructed not to prepare documentation for them. Finally the report identifies standards that are satisfied by parent program policy and procedure statements, but need further documentation to verify implementation at the local program. The report is distributed by Accreditation Office staff to the program and to members of the audit team visiting programs within that system.

Re-audit

In the event that a program is found to be in non-compliance with one or more mandatory standards or lacks sufficient compliance levels at the time of the original audit, a re-audit may be required. The re-audit is a visit to the program that entails a re-evaluation of compliance with mandatory and/or other standards necessary to meet accreditation requirements. The cost of the re-audit is assumed by the program and is determined on a cost plus twenty-five percent basis. The team leader or another member of the original audit team will return to the program to audit the appropriate standards.

When a re-audit is required, the program is responsible for notifying the Accreditation Office when the deficiencies have been corrected. Arrangements for the re-audit, including scheduling, transportation, and accommodations are handled in the same manner as for the standards compliance audit. The program may also request a re-audit of any standards found in non-compliance during the initial audit. The number of standards reviewed and the length of the visit are determined in advance by Accreditation Office staff.

Re-audit activities follow a format similar to those involved in the standards compliance audit. Generally, the audit team member meets briefly with program staff and takes a short tour of the program sites before beginning a re-examination of documentation. All basic auditing principles are applicable on a re-audit, i.e., review of documentation, communication with program personnel, and interviews. Upon finishing the review of standards compliance documentation, the auditor meets with the program administrator and designated staff to report the new findings. The exit interview is conducted in the same manner as that of the standards compliance audit, entailing review and explanation of audit findings.

Following the visit, a written report of audit activities is submitted to the Accreditation Office. The re-audit report briefly addresses the conduct of the visit, observations made on the tour, the result of interviews, and any changes in compliance findings since the original audit. This report is combined with the original audit team report for use by the Accreditation Office when considering the program's accreditation application.

The Audit Team's Report

The results of the standards compliance audit are contained in the audit team's report. The finished report consists of a number of sections, which are compiled through an exchange of information between the audit team, the program, and Accreditation Office staff. All sections of the report are sent to staff for review and distribution to the program administrator and audit team members. The completed report is submitted to the Accreditation Office for consideration at the next regularly scheduled panel hearing.

The audit team report is prepared according to the following outline:

Audit Narrative - This section is prepared by the audit team leader and includes a description of program services, physical worksite and number of defendants served on the date of the audit. It also details audit activities and findings, including issues or concerns that may affect the quality of life and services in a program, as well as information and impressions obtained during interviews with staff and defendants.

Compliance Tally - The tally is completed by the audit team leader using a standard checklist form prepared by the Accreditation Office. Compliance percentages are calculated based on audit findings.

Audit Findings - Each standard found non-compliant or non-applicable is outlined, as well as the reasons for the findings.

Reports for probation, multi-county or statewide service pretrial programs audits follow a different procedure. The results of visits to all field offices audited are combined into one program report. For purposes of accreditation, if one field office is found in noncompliance with any standard(s), the program (regardless of the number of field offices) is found in noncompliance with the standard(s).

Issues or concerns about compliance, as well as information and impressions obtained during interviews with staff, are highlighted in the report.

The following sections are added to the audit team report subsequent to the report being submitted to the program that was audited for their comments.

Program Response - This section contains the program's response to each non-compliance finding (i.e. plans of action, waivers, or appeals.)

Auditor's Response - This section contains the audit team's final response to all comments received from the program and Accreditation Office staff, including:

* comments on program appeals of the audit team's findings stating whether or not the committee agrees with the appeal
* comments regarding the acceptance or rejection of waiver requests
* comments on the acceptability of plans of action.

Non-compliant Standards

Compliance with all applicable standards designated as *mandatory* is a prerequisite to accreditation. Following their receipt of the audit report and prior to the accreditation hearing, the program is required to respond to each standard found in non-compliance. Response is achieved with a plan of action, discretionary compliance request, waiver request, or an appeal.

Plans of Action

The NAPSA Accreditation policy is to encourage agencies to take all reasonable and necessary measures to come into compliance with any non-mandatory standard that the audit team finds the program in non-compliance at the time of the audit. When the non-compliance decision is sustained by the Office, a plan of action must be developed to correct the deficiencies. The plan of action specifies:

- the statement of deficiencies
- description or summary of actions necessary to achieve compliance

- tasks to be completed
- the responsible program and personnel from that program for completing the tasks
- timetables to be met.

For programs operating under a parent program, the plan of action requires both the individual program being audited, as well as the parent program (for example, the probation department), to list activities that will be required to achieve compliance with a particular standard. Parent agencies must sign off on plans of action as evidence of their support for the approach. Thus, both the program and the parent program are held accountable for activities to achieve compliance with certain standards.

In judging the acceptability of plans of action, the feasibility of plans to achieve compliance will be reviewed by the audit team and the Accreditation Office, including specific tasks, time frames, and resource availability (staff and funding) for implementing the proposed remedies. In addition, the Office will look at whether the proposed plan of action is of a repetitive nature, i.e., either it repeats a plan of action previously submitted to the Office, albeit with new dates inserted, or it reframes the plan, carrying essentially the same steps for one, two, or three more years. The Office does recognize that not all programs will be able to comply with all non-mandatory standards. As a means to avoid the concerns raised by repetitive plans of action, options such as waivers and designations of standards as discretionary are available to agencies.

Given the options available, and absent evidence of good faith efforts and some progress towards compliance pursuant to a plan of action, the Accreditation Office's policy is to view such repetitive plans of action as an attempt on the part of the program to delay or avoid compliance with a standard. This may be grounds for the panel taking certain actions such as ordering interim/ongoing compliance reports, monitoring visits, placing the program on probation (one year) or even denying reaccreditation in extreme cases.

Waivers

Compliance with all standards (or all standards with one plan of action) designated as mandatory is a prerequisite to accreditation. The Accreditation Office views 100 percent compliance with non-mandatory standards as a goal. It recognizes that when a program participates in the accreditation process, it may not always be possible for the program to comply immediately, or at all, with all of the applicable standards. While still encouraging progress toward 100 percent compliance with the standards over time, the Accreditation Office recognizes circumstances under which a plan of action may not be required for a non-mandatory standard noncompliance.

In some cases the non-compliance is due to the program being *unable* to achieve compliance because:

- a state statute specifically *prohibits* compliance
- an existing physical workspace cannot be modified or relocated without substantial expenditures
- repeated unsuccessful attempts have been made (and can be documented) to obtain funding to achieve compliance.

In these instances, if the program can provide documentation to show that it has taken measures to mitigate the specific negative impact of non-compliance with the intent of the standard, it may apply for a waiver of the requirements for developing a plan of action. The waiver request must satisfy four requirements:

- one of the three eligible circumstances stated above
- documentation regarding mitigation
- no adverse effect on staff or defendants
- no adverse effect on the operation of the program.

The burden of proving that a waiver is warranted rests with the applicant program. The granting of a waiver does not change the conclusion of non-compliance or alter the standards compliance tally. The Accreditation Office renders the final decision relative to the waiver request during the accreditation hearing.

In response to a waiver request, the Office may:

- grant a waiver for the non-compliant standard
- waive part of the standard and specify that the program submit plans to meet the remaining requirements of the standard (this may occur with standards that contain several different requirements)
- deny the request for the waiver and require a plan of action from the program to meet the standard
- deny the request and grant discretionary compliance.

Appeals of Audit Team Findings

The audit team must make a finding for every standard of compliant, noncompliant or non-applicable. The program will have the opportunity at the accreditation hearing, which is described below, to appeal any findings of the audit team. Auditors are trained and required to render the strictest possible interpretations of standards during the audits. Only the Accreditation Office has the authority and discretion to consider appeals by a program and render interpretations relative to that program.

During the hearing, program representatives will be able to present the program's position relative to the Audit Team's findings with which it does not concur.

The program's opinion relative to the merit of a standard will not be grounds for an appeal.

The program will not be able to present documentation which did not exist at the time of the audit. It may provide additional documentation to the Accreditation Office which the audit team did not review, understanding that the burden of proof that the documentation existed at the time of the audit is on the program. The result of a successful appeal is a change in the status of the standard (compliance or applicability) and recalculation of the program's compliance tally. If the Accreditation Office denies the appeal, the program must submit a plan of action for the standard to the Accreditation Office. During the next accreditation audit, the program is responsible for meeting the terms of the submitted plan of action.

Discretionary Compliance

Waiver requests of non-mandatory standards are made in conjunction with a program's inability to comply, or where the program is complying with the intent of the standard but in a different manner than that proscribed. There are circumstances in which programs choose not to comply with a particular standard for a variety of reasons. These reasons include:

- An unwillingness to request funds from a parent program or funding source

- A preference to satisfy the standard/expected practice's intent in an alternative fashion
- An objection from a parent program, higher level government official, or funding source to the nature of the standard/expected practice
- A clear policy in place at a higher level that is contrary to the requirements of the standard/expected practice
- An existing provision in a collective bargaining agreement that makes compliance impossible (without bargaining with the employees' union to effect such a change).

When the program chooses not to comply with a non-mandatory standard, it should notify the Accreditation Office staff on the response to non-compliance form that it has elected to select the particular standard as a "discretionary compliance." In such instances, the burden is on the program to:

- provide the rationale for identifying the standard as discretionary (i.e., one of five reasons identified above)
- describe the condition generating the request and how non-compliance will not adversely negatively affect staff or defendants, or clients, or the operation of the program.

The election of discretionary compliance use may be exercised at the program's discretion. The following condition is applicable whenever the discretion is applied:

- A program may designate one of the applicable non-mandatory standards as discretionary. However, it must be in compliance with the other non-mandatory standards, or working toward full compliance by submission of an action plan.

At the Accreditation Hearing a dialogue may occur between program representatives and the Accreditation Office relative to encouraging the program to consider a plan of action in the future. The Commission may also offer suggestions as how to achieve compliance should the program decide to reconsider the discretionary designation at the panel hearing or at some point in the future.

Programs may designate a standard as discretionary to Accreditation Office staff and the auditors, and that designation may change to a plan of action after discussion with the Commission. Once a program designates a standard as discretionary during one accreditation cycle, it may elect to change to a plan of action or, of course, comply with the standard/expected practice in the course of a subsequent cycle.

Accreditation Hearing

The NAPSA Commission on Accreditation is solely responsible for rendering accreditation decisions and considers a program's application at its next regular meeting following completion of the audit team report. The Commission is divided into two panels -- one for release and, one for diversion -- that are empowered to reach and render accreditation decisions. These panels hear the individual application for accreditation and include three Commissioners which include the panel hearing chairperson. Programs are notified in writing of the date, time, and location of the hearings by Accreditation Office staff. Tele-conferences are permissible.

The panel hearing is the last step in the process. With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of program operations and participation in the accreditation process. The information presented during the hearing and in the audit team report is considered by the panel members in rendering accreditation decisions.

The program is invited to have at least one representative at the hearing. When special conditions warrant, the audit team leader or a member of the audit team also may be asked to attend the hearings. When this occurs, the auditor provides information to help clarify controversial issues and responds to questions and concerns posed by panel members.

Attendance by any other parties (i.e. media representatives, public officials, or personnel from agencies other than the applicant) is not allowed; however written communications will be accepted.

The panel schedule provides ample time for review of each individual program pursuing accreditation. Hearings are conducted by the panel chairperson in accordance with established procedures, described below. Panel proceedings require that a formal vote be taken on all final actions, i.e., program appeals, waiver requests, and the final accreditation decision of the Commission. All panel proceedings are tape-recorded to assist in preparing minutes of the hearings. Panel activities generally occur as follows:

- applicant program representatives are requested by Accreditation Office staff to be on-call to allow for scheduling flexibility
- a designated waiting area is usually provided for this purpose
- when the panel is ready to review the all the materials relating to the audit, the Accreditation Office staff representative notifies program representative(s)
- the hearing opens with an introduction by the panel chairperson
- the program representative is asked to give a brief description of the program.
- if an audit team member is present at the hearing, the panel chairperson may request that the auditor present an account of the visit, focusing on matters particularly pertinent to the decision or specific panel actions. In some cases, however, the panel may wish to call on the audit team member only to request additional information at different points during the hearing
- the panel chairperson leads a standard by standard review of non-compliance issues. The program representative presents information relative to their requests for waivers, plans of action, appeals, and discretionary compliance requests. The program may also present additional materials, or documentation, for review by the panel.
- following the program presentation, the chairperson has the option of calling the panel into executive session to consider the information provided, determine findings, and make an accreditation decision. Whether or not panel deliberations occur in the presence of program personnel or in executive session, varies from panel to panel, considering the preference of panel members and the sensitivity of issues to be discussed regarding the application.

In final deliberations, the Commission panel:

- ensures compliance with all mandatory standards, or compliance with all but one mandatory standard and an action plan for implementation for that standard
- responds with a formal vote to all appeals submitted by the applicant program
- responds with a formal vote to all requests for waivers, discretionary compliance, and plans of action submitted by the applicant program.

At this time, the panel also

- assures that an acceptable plan of action will be submitted for every non-compliant standard, including those standards for which appeals of non-compliance and waiver requests have been denied by the panel. In judging the acceptability of plans of action, the panel ensures that

all of the information requested on the form is provided. Furthermore, the feasibility of plans to achieve compliance is considered, including specific tasks, time frames, and resource availability (staff and funding) for implementing proposed remedies.

- addresses to its satisfaction any concerns it has with audit team comments about the quality the worksite or program, patterns of non-compliance, or any other conditions reviewed by the panel relating to standards.

For each application, a roll call vote to award accreditation, extend a program as a candidate or correspondent, or deny accreditation is conducted. The options for final action available to the panel are outlined in the next section.

If the panel has deliberated in executive session, program representatives are invited back into the meeting and informed of the panel's final decision and actions or recommendations on all other issues raised by the applicant. If accreditation has not been granted, the chairperson discusses with program personnel specific reasons for the decision and the conditions of extension in Candidate or Correspondent Status and procedures for appeal.

Accreditation Decisions

The decisions available to the Commission panel relating to the accreditation of a program are:

- *Three-year accreditation award* based on sufficient compliance with standards and acceptance of adequate plans of action for all non-compliant standards. The balance of the fees must be paid in full in order to receive a certificate of accreditation.

- *Probationary Status* is determined when the panel specifies that compliance levels are marginal, there is a significant decrease in compliance from the previous audit (in the case of reaccreditation), or there are worksite issues that would indicate continued monitoring. While an award of accreditation is granted, a monitoring visit *must* be completed and the report presented at the next meeting of the Commission. The cost for a monitoring visit is borne by the program at a rate of cost plus 25%. The program does not have to appear before the Commission for the review of the monitoring visit report. If they choose to do so, all related travel expenses are borne by the program. Specific expectations for removal from probation are outlined.

- *Extension of the applicant program as a "Candidate"* (initial accreditation only) for reasons of insufficient standards compliance, inadequate plans of action, or failure to meet other requirements as determined by the panel. The Commission may stipulate additional requirements for accreditation if, in its opinion, conditions exist in the program that adversely affect the delivery of pretrial release or diversion services. Extension of an applicant as a "Candidate" is for a period of time specified by the panel and for identified deficiencies if in the panel's judgment, the program is actively pursuing compliance.

- *Denial of accreditation* removes the program from Accredited Status (in the case of reaccreditation) and withdraws the program from the accreditation program. Situations such as insufficient standards compliance, inadequate plans of action or failure to meet other requirements as determined by the panel may lead to the denial of accreditation. If a program is denied accreditation, it is withdrawn from the process and is not eligible to re-apply (as an applicant) for accreditation status for a minimum of six months from the date of that panel hearing. The Commission will explain the process for appeal. (See below)

The program receives written notification of all decisions relative to accreditation after the hearing.

Appeal of Accreditation Commission Decisions

The accreditation process includes an appeal procedure to ensure the equity, fairness, and reliability of its decisions, particularly those that constitute either denial or withdrawal of Accredited Status. Therefore, a program may submit an appeal of any denial or withdrawal of accreditation.

The basis for reconsideration is based on grounds that the decision(s) were:

- arbitrary, capricious, or otherwise in substantial disregard of the criteria and/or procedures promulgated by the Commission
- based on incorrect facts or an incorrect interpretation of facts
- unsupported by substantial evidence.

The reasonableness of the standards, criteria, and/or procedures for the process may not serve as the basis for reconsideration. The procedures for reconsideration are as follows:

- The program submits a written request for reconsideration to the Director of Accreditation within 30 days of the adverse decision stating the basis for the request.

- The Accreditation Commission, composed of the appropriate panel of either Release or Diversion, reviews the request and decides whether or not the program's request presents sufficient evidence to warrant a reconsideration hearing before the Commission. The program is notified in writing of the Committee's decision.

- If the decision is made to conduct a reconsideration hearing, the hearing is scheduled for the next full Commission meeting and the program is notified of the date.

- The program, at its option and expense, has the right to bring persons to the reconsideration hearing to give testimony, or participate in teleconference.

- Following the reconsideration hearing the Commission’s decision, reflecting a majority opinion, is made known to the program within 30 days.

- Pending completion of the reconsideration process, the program maintains its prior status. Until a final decision has been reached, all public statements concerning the program's accredited status are withheld.

- Following completion of the reconsideration process, any change in the status of a program is reflected in the next regularly published list of accredited agencies.

STAGE FOUR: ACCREDITED STATUS

The accreditation period is three years, during which time the program must maintain the level of standards compliance achieved during the audit and work towards compliance of those non-mandatory standards found in non-compliance. Regular contact with Accreditation Office staff should also be maintained.

Annual Report

During the three year accreditation period, the program submits an annual report to the Accreditation Office. This statement is due on the anniversary of the accreditation (panel hearing) date and contains the following information:

Current standards compliance levels - This includes any changes in standards compliance since accreditation, listing on a standard-by-standard basis any standard with which the program has fallen out of compliance or achieved compliance.

Update of plans of action - A progress report is included with respect to plans of action submitted to the hearing panel, indicating completion of plans resulting in compliance with standards and revised plans reflecting the need for additional time, funds, and/or resources to achieve compliance.

Significant Events - A report is made of events and occurrences at the program during the preceding year that impact on standards compliance, program operation, or the quality of services provided by the program. This might include:

- a program change in the program administration and/or major staffing changes
- funding changes
- mission change or program revisions
- changes in the defendant population, including number of defendants or general defendant profile
- physical plant renovations, additions, or closings and impact on program
- any major disturbances, such as, employee work stoppages, etc.

Accreditation Office staff review the annual report received from the program and respond to clarify issues or request additional information if necessary.

In addition to submission of the annual report, the program is responsible for notifying Accreditation Office staff of any major incident, event, or circumstance that might affect standards compliance. This notice must be provided to the Accreditation Office immediately following the event. For example, a program must notify the Accreditation Office if it is the subject of a court order, has a major disturbance, employee work stoppage, or experiences a major fire or other disaster. It is the responsibility of the accredited program to inform Accreditation Office staff or provide them with copies of news articles, special reports, or results of investigations that address conditions that affect standards compliance.

Finally, the Accreditation Office may request that the program respond to public criticism, notoriety, or patterns of complaint about program activity that suggests failure to maintain standards compliance. The Accreditation Office may conduct an on-site monitoring visit to the program to verify continued compliance.

Monitoring Visits

Monitoring visits to programs in Accredited Status are conducted by a NAPSA auditor(s) in order to assess continuing compliance with the standards. A monitoring visit may be conducted at any time during the accreditation period, with advance notice to the program. There must be a valid stated reason for why the visit is necessary. The Accreditation Office will not arbitrarily schedule a visit. The determination of need for a monitoring visit is based on:

- compliance levels, findings, and recommendations by the Commission on Accreditation for NAPSA during the hearing
- incidents or events reported by the program in its annual report
- problems indicated by adverse media reports or correspondence received by Accreditation Office staff, disturbances at the program, or special investigations.

The length of the visit varies depending on the number of standards or special issues that must be addressed during the visit. The visits are conducted similar to standards compliance audits, but on a reduced scale. Monitoring visits are charged to the program at a rate of cost plus twenty-five percent.

Monitoring visit activities, as a general rule, involve a review of all mandatory standards, all non-mandatory standards found in non-compliance at the time of accreditation, and any other concerns identified by the Commission. The visit also involves a tour of the program space and interviews with staff to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the program staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit. The report includes a list of standards reviewed, explanation of non-compliance findings, results of the tour and interviews with program staff, and discussion of any issues believed to be relevant to the program's accreditation. The report, as with others prepared by auditors, is reviewed and sent to the program by Accreditation Office staff.

When a monitoring visit to the program reveals deficiencies in maintaining compliance levels that existed at the time of accreditation, or less than 100 percent compliance with mandatory standards (or all but one mandatory standard plans are action plan for the one standard not in compliance), the program prepares a response providing explanation of the problems indicated in the report. When the program has failed to maintain compliance with all mandatory standards, the monitoring visit report and the program response are submitted to the Commission on Accreditation for NAPSA for review during a regular hearing. Program representatives are advised of the date, time, and location of the review, and are invited to attend. At the discretion of the Commission, the program may be placed in probationary status and a revisit conducted to determine if deficiencies have been corrected.

Probationary Status

If the Commission panel believes that a program's failure to attain continuous compliance with certain standards, the Commission may place a program on probation. Probationary status lasts for a specific period of time designated by the Commission to allow for correction of deficiencies. At the end of the probationary status, another monitoring visit or submission of documentation will be conducted to ensure that the deficiencies have been corrected. The cost of this visit is borne by the program. Following the visit, a report is prepared for review by the Commission at its next regularly scheduled meeting. The Commission again reviews the program and considers removing the probationary status or revoking accreditation. When the program corrects the deficiencies within the probationary status period and the corrections have been verified and accepted, the program resumes its status as an accredited

program. A program that does not satisfactorily correct the deficiencies may be withdrawn from accreditation.

Revocation of Accreditation

Accreditation is revoked for the following reasons:

- failure on the part of the program to adhere to the provisions on the contract
- failure on the part of the program to maintain continuous compliance with the standards at levels sufficient for accreditation
- intentional misrepresentation of facts, lack of good faith, or lack of deliberate speed or a concerted effort to progress in the accreditation process, including the implementation of plans of action
- failure to notify NAPSA of significant incidents in the annual report to the Commission
- adverse conditions that make it impossible to adhere to standards and contract requirements
- failure to comply with the conditions of probation or suspension.

Accreditation Office staff notify the program in writing of the specific reasons identified by the Commission for the revocation hearing. Programs may appeal the decision of the Committee to the full board of the Commission on Accreditation. Appeals must be submitted within 30 days. The program may apply to re-enter the accreditation process 180 days after the revocation of accreditation.

Expiration of Accredited Status

Accreditation is granted for a three-year period. Unless the program has applied for reaccreditation and completed activities in the process required for reaccreditation, the Commission withdraws the program from accredited status after this three year period.
For programs in accredited status that are seeking subsequent accreditation, administrative extensions of accredited status may be granted under certain conditions. For example, relocation of the facility, staff turnover, and major renovations often warrant an extension. In these cases, a written request to the Director of Accreditation is required, outlining the reasons for extending the accreditation period. An extension may last anywhere from one month to six months. Agencies that fail to successfully complete an audit within the three year period, or do not receive an extension prior to their expiration date, are withdrawn from accredited status.

STEP FIVE: REACCREDITATION

Eligibility

Agencies seeking reaccreditation must satisfy the criteria noted previously in this manual. In addition, the program must be in accredited status at the time application is made for reaccreditation. The timing of the program's application should allow for completion of the process in order to maintain the program's continuous accredited status. It is advised that the application be submitted nine months prior to the expiration of the program's current status. If the program has allowed the preceding accreditation to expire, a 90-day extension may be granted at the discretion of the Accreditation Office. If the program is not reaccredited after that extension, it again applies the process required of agencies seeking initial accreditation unless there is a significant event as outlined in Stage Four where upon the program may apply for a further extension of three months.

Agencies seeking reaccreditation should be able to demonstrate efforts to improve upon compliance levels achieved during initial accreditation, including progress in completing plans of action.

Activities

As with the initial process, the reaccreditation applicant phase involves an exchange of information and materials between the program and Accreditation Office staff. Upon receipt of the signed contract and a completed organization summary from the program, the Accreditation Office notifies the program of its acceptance as a candidate for reaccreditation.

Tasks and responsibilities for programs seeking continuous reaccreditation involve an optional program self-evaluation of compliance with standards, organization of standards compliance documentation, completion of a standards compliance audit, and review of the program's application during an accreditation hearing.

For programs seeking a continuation of their three-year accredited status, documentation must indicate continuous compliance with the standards from the previous audit. Auditors for reaccreditation sample records, files, and logs dating back to the previous audit in order to determine if continuous compliance has been maintained.

Standards Compliance Reaccreditation Audit

The program's request and arrangements for a reaccreditation audit are the same as for agencies proceeding through accreditation for the first time.

The audit format and activities remain basically the same; however, the subsequent audit focuses not only on compliance at the time of the audit, but also on compliance levels throughout the three-year period. During the subsequent audit, audit team members seek confirmation that the program has maintained continuous compliance and looks for program progress in correcting earlier deficiencies in standards compliance.

Audit Team Report

The format and time frames for completing the audit team report remain the same as those described earlier in this manual. For audits of agencies seeking reaccreditation, the following information may also be included in the visiting committee report:

- comments concerning standards remaining in non-compliance since the prior audit, including progress on plans of action
- an indication of major changes in program operation or programs affecting standards applicability or compliance
- discussion of special issues noted in the previous audit or accreditation period.

Accreditation Hearing

For agencies seeking reaccreditation, the same conditions required for initial accreditation apply. In addition, the Commission reviews the program's progress in achieving compliance with standards found in non-compliance at the time of the previous accreditation period. The program must be able to demonstrate a good faith effort and/or progress in improving standards compliance levels and addressing concerns that may have arisen during an earlier accreditation period.

Appendix A

Date Received: _____

Date Posted: _____

NOTICE
THIS PROGRAM IS AN APPLICANT FOR ACCREDITATION

- The Office of Accreditation of the National Association of Pretrial Services Agencies. Association is private, non-profit organizations directing the accreditation of pretrial programs in the United States.

- **[NAME OF PROGRAM]** is voluntarily seeking accreditation by the Office of Accreditation for Pretrial Service by demonstrating its compliance with nationally established standards.

- The Office of Accreditation will conduct a standards compliance audit of this program on **[DATE]**.

- Information relevant to this program's compliance with standards should be submitted in writing to the NAPSA, Accreditation Office, at least 10 working days prior to the audit. Please send all materials or comments to:

Accreditation Office
660 N. Capitol Street NW
Suite 400
Washington, DC 20001
877-855-7438

Appendix B

Organization Summary

Please complete a separate summary for each program or facility and return to the NAPSA.

1.	Name of Program/Facility:					
	Physical Address:					
	Mailing Address: (if different from above):					
	Primary Facility Telephone Number:					
2.	Name: [Exec. Dir. or Office]					
	Title:					
	Telephone Number:					
	E-mail Address:					
3.	Accreditation Manager:					
	Title:					
	Telephone Number:					
	E-mail Address:					
4.	State/Regional Accreditation Manager (if applicable):					
	Title:					
	Telephone Number:					
	E-mail Address:					
5.	Operations Director:					
	Title:					
	Telephone Number:					
	E-mail Address:					
6.	Program Administrator:					
	Title:					
	Telephone Number:					
	E-mail Address:					
7.	Governing Authority or Parent Program:					
8.	Standards manual that will be followed to obtain accreditation:					
9.	Accreditation Status:		Initial		Reaccreditation	
10.	Date of last accreditation (reaccreditation only):					

Appendix B
(continue)

11.	Airport Preference (Please list one or two airports that you would like the audit team to fly into or out of.)										
	1st Preference:										
	Distance from the facility:		miles								
	2nd Preference:										
	Distance from the facility:		miles								
12.	The program is: (check one)	Federal ■	State ■	County ■	Municipal ■	Private not for profit ■					
13.	Date the program was constructed or established:										
14.	State the mission of the program (attach additional pages if necessary):										
15.	Average yearly volume serviced:		Average daily population for the last 12 months:								
16.	Age range of the Population:	Adults	%	Juveniles	%	Youthful Offenders	%				
17.	Age of criminal majority in your jurisdiction:	%									
18.	Name of satellite program:										
	Physical Address:										
	Mailing Address (if different from above):										
	Primary Telephone Number:										
	Distance from the court:										
	Number of satellite staff:										
19.	Total number of full-time staff by category										
	Line staff		Administrative support:		Security:		Other:				
20.	Average length of stay or time under supervision	Years:		Months:		Days:					
21.	Physical worksite description										
22.	Summary description of program: (attach additional pages if necessary)										

Appendix C

Response to Non-compliance Form

Standard

RESPONSE TO NON-COMPLIANCE

Submit one of the following for the non-compliant standard referenced above.

1. Plan of Action

   Please explain completely the corrective action that will be taken to comply with the standard.

In the order of anticipated completion dates, list the tasks necessary to achieve compliance, the responsible program (including parent program), and assigned staff member.

Task

a.

b.

c.

Responsible Program

a.

b.

c.

Assigned Staff

a.

b.

c.

Anticipated Completion Date

a.

b.

c.

Appendix C
(continued)

2. **Waiver Request**

Indicate why the requirement for compliance should be waived.

3. **Appeal of the Visiting Committee Finding**

Indicate your reason for disagreeing with the audit team's finding of non-compliance.

4. **Discretionary Compliance Request** Please check the following reasons that apply for requesting a discretionary compliance

- ■ An unwillingness to request funds from a parent program or funding source.
- ■ A preference to satisfy the standard/expected practice's intent in an alternative fashion. An objection from a parent program, higher level government official or funding source to the nature of the standard/expected practice.
- ■ An existing provision in a collective bargaining agreement that makes compliance impossible (without bargaining with the employees' union to effect such a change.)

Describe the condition generating the request and how non-compliance will not adversely affect, in a significant manner, or the ability of the program to function effectively and not affect the program's compliance with mandatory standards or list practices.

Program Representative: _____ **Date:** _____

Appendix D

Standards Compliance Checklist

[SEE ATTACHED DOCUMENT]

Appendix E

Standards Compliance Tally

STANDARD	COMPLIANCE FULL	COMPLIANCE PARTIAL	IF PARTIAL, COMPLIED WITH	IF PARTIAL, NOT COMPLIED WITH	PLAN OF ACTION SUBMITTED Y/N	NOT APPLICABLE (LIST STANDARD BY NUMBER)	COORDINATOR INITIALS	AUDITOR INITIALS

Appendix F

Significant Incident Summary

[Description]