

Arkansas Department of Education

Division of Elementary & Secondary Education

School-Based Mental Health

Manual and Certification Application

School Health Services

Updated: September 2021

**Division of Elementary & Secondary Education**

**School-Based Mental Health**

**Manual and ADE Certification Application**

The Division of Elementary and Secondary Education (DESE) office of School Health Services (SHS) provides guidance and technical assistance for the development of best practice, school-based mental health programs within Arkansas public school districts. The DESE encourages schools to implement the following best practice principles to ensure quality school-based mental health services for students:

* An emphasis on early identification
* Full integration with the community and its resources
* Placing students and their families at the center of service decisions
* Providing services that are culturally competent
* A focus on promoting school attendance and academic success
* Services and supports validated by research and evidence-based practices
* The use of technology, including telecommunications

Access to a full array of mental and behavioral health services is promoted at the school site within these programs. Best practice school-based mental health services are characterized by the following:

* Student Supports
* Depending on the needs of students, an array of “pullout” interventions, including evaluation, crisis services, diagnosis, individual, group, family therapy, case management and day treatment
* Comprehensive intake, referral, and case management processes
* A collaborative partnership between school district and mental health provider staff that includes a comprehensive Memorandum of Understanding.
* Access to school-based mental health services without regard to student or family Medicaid enrollment status.
* Appropriate linkages with community, regional, state and national resources
* Participation in Title XIX, Medicaid, either through provider enrollment or purchased service contracts
* Maximum utilization of alternative funding streams, including third party payers, public targeted and competitive grants, and private foundation funds.

# **School-Based Mental Health Medicaid Provider Criteria**

School districts must meet specific certification and provider enrollment criteria to become an approved behavioral health Medicaid provider. School districts are expected to adhere to the standards and guidelines established by the DESE, the Division of Behavioral Health Services (DBHS), and the Arkansas Division of Medical Services (DMS). The following outlines the necessary criteria required for a SBMH program to become an approved behavioral health Medicaid provider:

* Obtain SBMH application approval outlining service program.
* Obtain Arkansas Medicaid provider approval of the enrollment application <https://humanservices.arkansas.gov/wp-content/uploads/ApplicationPacket.doc>

# **School-Based Mental Health Delivery Models**

School district SBMH program service delivery models vary in structure depending on personnel and partnerships. Regardless of model choice, all certified SBMH programs promote mental health services with professionalism, quality and accountability. ADE recommends school districts follow best practices as outlined in this guidance document.

School District as Medicaid Service Provider Model:

1. The District has an approved ADE SBMH Certification.
2. The District designates a SBMH Program Coordinator/Liaison.
3. The District has an active SBMH Medicaid Provider Number.
4. The District acts as the billing agent for SBMH services provided to students during the school day.
5. A district-employed Licensed Mental Health Professional (LMHP) provides direct services to students during the school day.

School District/Provider Partnership Model:

1. No ADE certification approval required.
2. The District designates a SBMH Program Coordinator/Liaison.
3. The school district contracts with mental health provider (agency or individually licensed) to provide services.
4. The mental health provider acts as the billing agent for services.
5. The mental health agency has a MOU in place with the district to provide direct services to students during the school day.

Combination of above Models:

1. The District has an approved ADE SBMH Application.
2. The District designates a SBMH Program Coordinator/Liaison.
3. The District and the agency have an active SBMH Medicaid Provider Number.
4. The district and/or mental health provider act as billing agent for respective services provided.
5. A district-employed Licensed Mental Health Professional (LMHP) provides direct services to students during the school day.
6. The Mental health agency supplies treatment staff to the district to provide direct services.

# **Best Practices within Delivery Models**

**Program Needs Assessment:** A needs assessment is recommended to collect data on school district and provider needs as well as specific student population needs. Nationally recognized assessment tools recommended for this purpose are the Mental Health Planning and Evaluation Template and the School Health Assessment and Performance Evaluation System (SHAPE). Links to these assessment tools are provided below.

|  |  |
| --- | --- |
| The Mental Health Planning and Evaluation Template (MHPET) | <http://ww2.nasbhc.org/RoadMap/MHPET/MHPETPaper.pdf> |
| The School Health Assessment and Performance Evaluation System (SHAPE) | <https://theshapesystem.com/> |

**Service Delivery:** Delivering best practice mental health services in the schools includes one FTE therapist per 500 students with an active caseload of 20-30 students. Districts that are unable to adhere to best practice models initially will develop a timeline to include coverage plans for the future. Mental Health providers partnering with the school district are expected to split their time between indirect and direct services.

**Indirect Services**: As a best practice, thirty percent (30%) of time is dedicated to non-billable services such as prevention, education and early intervention services.

* + - 1. Classroom consultation/observation
      2. Student Services Team staffing
      3. Support Groups for students
      4. Parent Education
      5. Staff Meetings
      6. In-Service Trainings

**Direct Services**: As a best practice, seventy percent (70%) of time is dedicated to billable, direct services.

* + - 1. Assessment and diagnostic evaluations
      2. Individual behavioral health counseling
      3. Group behavioral health counseling
      4. Family behavioral health counseling
      5. Collateral contacts
      6. Treatment planning
      7. Treatment coordination
      8. Referrals to appropriate mental health/community services

More detailed information on direct and indirect services may be found in the Arkansas Medicaid Provider Manual found at <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/sbmh-prov/>.

**Programming:** Both program policy/procedures and a formalized contract are vital pieces in establishing a high quality SBMH program. Samples and additional resources along with a toolkit are available by contacting the DESE School Health Services office or on the DESE School-Based Mental Health website found at <https://dese.ade.arkansas.gov/Offices/learning-services/school-health-services/school-based-mental-health-sbmh>.

# **Program Financial Sustainability**

SBMH programs offer mental health services to all students and families not dependent upon Medicaid eligibility or private insurance coverage. Considering this policy, issues related to funding are critical to the development and expansion of SBMH services. All potential funding sources should be considered when managing a SBMH program. A SBMH program cannot sustain itself based on just one funding source.

**Medicaid Billing:**

In order to bill Medicaid for mental health services, a school district (or mental health partner) must be enrolled as a provider. This is accomplished by submitting a provider enrollment application to Medicaid upon ADE approval of the district’s SBMH application. Medicaid-enrolled districts are capable of receiving the following per unit reimbursement for the indicated service:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Proc Code | Description | Unit of Service | Rate | Daily Benefit Limit (#units) | Annual Benefit Limit (#units) |
| 90832 | Individual Behavioral Health Counseling | 30 Minutes | $46.38 | 1 across these 3 codes | 12 across these 3 codes |
| 90834 | Individual Behavioral Health Counseling | 45 Minutes | $69.57 |
| 90837 | Individual Behavioral Health Counseling | 60 Minutes | $92.76 |
| 90791 | Mental Health Diagnosis | Encounter (Est.60 min) | $114.43 | 1 | 1 |
| 96101 | Psychological Evaluation | 60 Minutes | $81.49 | 4 | 8 |
| 90887 | Interpretation of Diagnosis | Encounter (Est.30min) | $53.65 | 1 | 1 |
| 90847 | Marital/Family Behavioral Health Counseling w/ Beneficiary Present | Encounter (Est.45 Min) | $77.28 | 1 | 12 |
| H2011 | Crisis Intervention | 15 Minutes | $27.30 | 12 | 72 |
| 90853 | Group Behavioral Health Counseling | Encounter (estimated @ 45min) | $47.46 | 1 | 12 |

The above rates are periodically subject to change. Please see the [School Based Mental Health Services Fee Schedule](https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/#current-fee-schedules) to verify current billable rates.

School districts that receive reimbursement from Medicaid for SBMH services are required to use state and local funds to pay the match payment back to Medicaid on a quarterly basis.

**Private Insurance:**

When a student has private insurance, as well as Medicaid, the school district will have to make a reasonable attempt to secure payment for services from the private insurance company before submitting a claim to Medicaid (per Title 43 CFR, Part 433, Subpart D).

**Grant and Private Foundations:**

In order to expand on current services, school districts and mental health partners should actively pursue grant opportunities (i.e. SAMSHA, others) through ongoing research and communication with potential lenders at the national and community level.

Many health programs are sponsored by private foundations (i.e. Wal-Mart, Federal Express). School districts and mental health partners will need to make attempts to obtain resources from the private sector in order to develop or expand services in their area.

# **School-Based Mental Health Provider Enrollment Medicaid in the Schools (MITS)**

Medicaid in the Schools (MITS), a special program within the DESE School Health Services Unit at the Arkansas Department of Education. Once a school district has SBMH certification, the next step starts at Medicaid in the Schools. MITS is available to assist with the Medicaid process beginning with the provider application through the steps for billing and contact information with the Medicaid state offices. Public school districts that employ their own therapists can enroll as a provider in the Arkansas State Medicaid Program. Districts must submit a Medicaid provider application to Arkansas Medicaid.

The Arkansas Medicaid Provider Enrollment Application Packet can be found at: <https://humanservices.arkansas.gov/wp-content/uploads/ApplicationPacket.doc>.

Instructions for completing the Medicaid Provider application can be found at the following link: <https://drive.google.com/file/d/1O2i4a5ytJi9qTk3YdGW6yoQxO7qgXG_6/view>.

The completed Arkansas Medicaid Provider Enrollment Application should be sent to the DESE School Health Services Office, ATTN: MITS Specialist, Four Capitol Mall, Slot 14, Little Rock, AR 72201. MITS will deliver all completed applications to provider enrollment and track the applications.

Medicaid Provider Enrollment Unit, Gainwell Technologies, will process all provider applications. Upon approval, the DESE School Health Services MITS Specialist will forward the DHS approval letter to the LEA with their provider number. Individual providers will receive a letter from the Department of Human Services (DHS) with their provider number. Once the district receives this notification, the district can then begin the next steps to start the billing process. For provider enrollment assistance, contact Gainwell Technologies at 800-457-4454.

Schools enrolled as a Medicaid provider must follow the Arkansas Medicaid School-based Mental Health Provider manual for billing for services rendered. The following is the link to the manual: <https://dese.ade.arkansas.gov/Offices/learning-services/school-health-services/school-based-mental-health-sbmh>.

The district is responsible for submitting payment to the state quarterly for the federal match portion of any direct service reimbursement received by a public school enrolled as a Medicaid provider.

# **Role of Employees**

The SBMH best practice program model is based on quality, accountability and professional partnerships between school districts and mental health providers. Each program participant has an important role in the successful implementation of SBMH services. The following role descriptions are a guide for the duties and tasks performed by program personnel:

**Teachers:**

* Participate in the identification and referral of students in need of mental health services.
* Participate in the implementation of treatment/behavior plans for students involved in SBMH services.
* Provide feedback to Student Services Team on student progress.
* Provide academic information to the team.
* Includes the mental health practitioner in parent teacher conferences when there are emotional/behavioral issues to be addressed.
* Participates in program evaluation, accountability, and quality assurance activities.

**School Counselors:**

* Provide indirect services to include referring students for SBMH services (Tier 3 services-indirect).
* Provide direct services to students by supporting the implementation of treatment and/or behavior plans (Tier 2/3 services-direct).
* Help students and families cope with an array of problems, including identifying school and community resources (Tier 2/3 services-indirect).
* Provide support to SBMH providers through data collection related to academic achievement (grades, attendance, and discipline referrals) as part of the referral or follow-up process.
* Participate in program evaluation, accountability, and quality assurance activities.

**Mental Health Staff (Therapists, Behavior Assistants, etc.)**

* Expected to attend and participate in Student Services Team meetings. Duties will include, but is not limited to the following:
  + Communicates extensively and provides consultation, mental health education and prevention information.
  + Assists in determination of appropriateness for services.
  + Caseload staffing – provides appropriate feedback to assist education staff in the implementation of treatment/behavior plans.
  + Participates in DESE sponsored SBMH conferences and workshops.
  + Participates in the collection of mental health information and data on student outcomes.
  + Participates in program evaluation and quality assurance activities.

**Principals:**

* Building level program promoter.
* Supports staff participation in SBMH activities.
* Understands the relationship between SBMH services and school disciplinary policy.
* Participates in program evaluation, accountability, and quality assurance activities.

**Superintendents:**

* Approves district participation in SBMH.
* Promotes program throughout district.
* Holds staff accountable for program participation and criteria.
* Supports staff participation in SBMH activities on and off campus including statewide SBMH conferences and monthly/quarterly training workshops
* Promotes the utilization of district data in the evaluation of the SBMH program.
* Commits space, office machines, supplies to SBMH program.
* Works with CSH/LEA/SBMH Coordinator to identify long-term sustainability resources and strategies. This includes assisting in development of community partnerships with key employers, leaders, funding sources.
* Participates in program evaluation, accountability, and quality assurance activities

**Coordinated School Health Coordinator/ SBMH Coordinators/LEA Supervisors:**

* Acts as point person for SBMH between districts and DESE which includes but is not limited to assisting DESE Coordinators with the development and implementation of SBMH in their district.
* Responsible for developing the foundation throughout the district for the district’s participation in the SBMH which includes:
  + - 1. Garnering district support and approval for participation in SBMH.
      2. Educating district staff regarding national research on academic impact of SBMH services.
      3. Identifying potential mental health partners.
      4. Determining the district’s “readiness” to implement SBMH services.
      5. Preparing Network application for submission.
      6. Coordinating services between district and providers.
      7. Monitoring quality of services.
      8. Coordinating the collection and sharing of data on student outcomes.
      9. Identifying specific training needs for districts related to SBMH.
      10. Promoting SBMH Program via participation in statewide SBMH conferences.
      11. Working with Regional Facilitators to promote program development and expansion
      12. Providing feedback regarding on-going development and training needs.
      13. Identifying community leaders/supporters for potential funding sponsorships/partnerships.
      14. Participating in program evaluation, accountability and quality assurance activities.

**Mental Health Supervisors:**

* Support personnel’s participation in identified activities.
* Adhere to contractual agreements between agency and district.
* Adhere to professional supervision guidelines as established by state licensing boards.
* Support personnel’s participation in annual statewide SBMH
* Conferences and quarterly training programs sponsored by ADE.
* Participate with the CSH Coordinator/LEA and or SBMH Coordinator to identify program challenges, and provide solutions.
* Promote and participate in the gathering, sharing and analysis of student and program outcomes as part of program evaluation, accountability, and quality assurance activities.

**Billing Clerks:**

* Provides billing services for district’s SBMH program.
* Adheres to Medicaid billing guidelines.
* Participates in both on the job training and training programs aimed at billing processes.
* Ensures job codes in e-finance are accurate.
* Maintains accurate billing records for all services.
* Provides feedback to program directors regarding processes and outcomes related to billing.
* Participates in program evaluation and quality assurance activities (DESE site visits).

# **Education & Mental Health Provider Partnerships**

The SBMH Model adopted by the Arkansas Department of Education is based on a strong foundation of collaboration and cooperation between mental health providers and school districts. The following are the guidelines that frame the structure for high quality partnerships.

**SBMH Partnerships Consist of the Following Characteristics:**

1. Partners share information readily and easily, having established mechanisms to support this prior to implementation of the program through an interagency agreement and/or business associate agreement.
2. Partnerships are seen as a fully integrated team effort creating a “seamless” environment within the schools delivering student services, staff supports, and other services. SBMH partners will utilize Student Services Teams to keep abreast of student progress and problem solve any current issues.
3. Partners participate in planning strategies and interventions that

impact individuals and systems in a positive way.

1. Partners recognize the value each brings to the table while creating and maintaining a shared agenda.
2. Partners participate in data management and analysis.
3. Partners share responsibility for program success which includes:

* Supporting school program leadership
* Program development and enhancement
* Working towards “best practice”
* Weekly communication
* Education and stigma busters
* Elimination of barriers to services
* Fiscal management
* Program sustainability
* Program accountability
* Program quality

# **Treatment Integrity**

SBMH programs will utilize a number of resources to document program effectiveness and outcomes. The basic purpose of program evaluation within programs is to systematically collect data to provide stakeholders with the information they need to make decisions about the program. Evaluation is an essential component within SBMH programs in order to document that services are effective and that scarce resources are not being wasted, in order to garner support from stakeholders (e.g., students, families, school personnel, community agencies, policy makers) and thus ensure program sustainability. Specific objectives of evaluation efforts are as follows:

**Program Evaluation Purpose:**

The major objectives of evaluation efforts within SBMH programs are as follows:

* To enhance the impact of SBMH programs by facilitating the improvement of service delivery mechanisms as well as quality of care.
* Additionally, evaluation efforts will assist programs in obtaining grant funding to support the services they provide and to assist ADE in identifying targeted training needs of SBMH program staff as well as school personnel who work day-to-day with students with disabilities (e.g., special education teachers).

**Program Evaluation Framework**

The SBMH Program Evaluation Standards are based on the Program Evaluation Standards proposed by the Joint Committee on Standards for Educational Evaluation (2011). The framework used in developing the SBMH Program Evaluation standards includes the following three components:

**Structure Evaluation**—Concerns the organizational characteristics of the program: its human, physical, and financial resources. Structure evaluation standards include (but are not limited to) mission, goals, outcomes, and service modalities.

**Process Evaluation**—Concerns implementation of the program, barriers and facilitators to implementation, population served, and services utilized. Process evaluation standards include (but are not limited to) implementation, referral processes, and service utilization.

**Outcome Evaluation**—Concerns the value of the program, achievement of objectives, positive and negative effects aside from its stated objectives, cost-effectiveness and sustainability. Outcome evaluation standards include (but are not limited to) program effectiveness, program impact, and sustainability.

**Application of Program Evaluation Standards**

SBMH programs will apply the Program Evaluation Standards and Framework and participate in data collection efforts with ADE. The Program Evaluation Standards are a minimum set of standards that SBMH programs will apply to the particular populations, settings, and services characteristic of the program being evaluated. Users are encouraged to become involved in refinement of the standards by assessing and reporting on the adequacy of the standards when applied in program evaluations. The following methods of data collection include, but are not limited to the following:

* The School Health Assessment and Performance Evaluation (SHAPE).
* Document review (e.g., SBMH documents/partnerships, site visit(s) with SBMH consultants, conference presentations, school district performance reports).
* Interviews between ADE SBMH Representative and SBMH representatives.
* Individual Outcomes Measures (e.g., Clinical, Behavioral).
* Consumer Satisfaction Surveys (e.g., Administrator, Youth, and Family).

# **Procedural Steps for SBMH Certification**

The following is an overview of the procedural steps required to meet the approval criteria for the SBMH Model:

1. **Program Initiation:**

* **Completion of SBMH Survey** (*See Attachment A*). School team and personnel will complete the SBMH Survey.
* **Complete and submit the SBMH Application Packet** (*see Attachment B*).The packet is submitted to ADE office of school health services and reviewed within 15 days. The office of school health services sends a letter to the school district, notifying them of the acceptance of the application. A copy of the certification approval letter is submitted via MITS to Provider Enrollment at Medicaid for the schools to bill for services. Approval letters are renewed every three years through the reporting process to ADE.

1. **Data Collection:**

* The school district must ensure district employed clinician job code assignments in eFinance reflect the license of which the practitioner is working.

|  |
| --- |
| Job Code:  9010 School Psychology Spec  9030 Educational Examiner  9035 School-Based Mental Health |
| Function Code: 2140 |

1. **Program Evaluation and Review:**

* After the program has been implemented, a formal interview and review may be conducted to evaluate the program. A representative from ADE’s Office of School Health Services may review the district/mental health provider policy and procedures, forms, clinical files, staffing patterns and interview all personnel involved in the program (*see Attachment C*).

# **SBMH Application Instructions and Definitions**

All school districts that wish to participate as an ADE certified SBMH program are required to submit an application for review and approval by ADE **every five years**. The application demonstrates a commitment to a collaborative partnership between the district and the mental health provider(s). See Attachment B for the ADE SBMH Application.

Applications are reviewed by ADE’s office of school health services within 15 days of submission and are evaluated for adherence to SBMH Program standards and requirements, quality, and completeness. Once the application has been reviewed, the office of school health services will either approve or return the application to the district for edits. Once ADE approves the application, a letter of certification is sent to the applying school district, documenting certification of their program.

In addition to the ADE Certification application, schools must also complete a Medicaid provider enrollment application. The Medicaid in the Schools office will assist districts in this process. The Arkansas Medicaid Provider Enrollment Application may access at the following link: <https://humanservices.arkansas.gov/wp-content/uploads/ApplicationPacket.doc>.

# **Attachment A**

# **SCHOOL-BASED MENTAL HEALTH**

# **BASELINE SURVEY**

Arkansas Department of Education

**SCHOOL-BASED MENTAL HEALTH**

**BASELINE SURVEY**

**ONLY FOR INITIAL CERTIFICATION**

**(Survey to be completed for each campus)**

**School District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LEA #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CSH Coordinator/ LEA Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Individual Completing Survey/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Building: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your district currently have School-Based Mental Health services? Yes/ No/ Not Sure**

***If yes, please name your provider(s)*:**

**Check the type of relationship your district has with your provider:**

**\_\_\_\_\_ Provider is a school employee \_\_\_\_\_Provider is on a purchase service agreement**

**Purchase Service Contract is with an: \_\_\_\_ Individual \_\_\_\_\_ Agency \_\_\_\_\_Other:**

**What services are provided? (Check all that apply)**

* **Individual Therapy**
* **Group Therapy**
* **Family Therapy**
* **Case Management**
* **Parenting Education**
* **Other \_\_\_\_\_ Please List:**

**How often are services provided?**

* **Daily**
* **Weekly**
* **Other**

**Is there a research component to the current program? Yes/ No/ Not Sure**

***If yes, name the instrument being used:***

**How satisfied are you with the current services being provided? Not Satisfied/ Satisfied/ Very Satisfied**

**How satisfied are you with your mental health provider? Not Satisfied/ Satisfied/ Very Satisfied**

**Please list other providers (as appropriate) that are present on your campus:**

**Are you interested in or in need of training on mental health problems and interventions? Yes/ No**

***If yes, please identify areas of need:***

**Are you interested in best practices school mental health services? Yes/ No**

**Please submit any additional comments:**

**School Staff Signatures (Superintendent, Principal, Nurse, School Counselor)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Title**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Title**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Title**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Title**

Please mail or email this document to the following contact:

Beth Mathys, M.Ed.

Dr. Betsy Kindall

Arkansas Department of Education

School-Based Mental Health Services

#4 Capitol Mall, Slot 14

Little Rock, AR 72201

# **Attachment B**

# **School-Based Mental Health Service Providers Certification Application**

***School-Based Mental Health Service Providers***

***Certification Application***

Each school district and prospective mental health partner must complete this application in its entirety in order to be considered for approval. This packet will precede the school district application to Arkansas Medicaid via MITS. Medicaid will not approve a provider number to a school district without a letter of approval from the Arkansas Department of Education. This packet must be submitted to the ADE regardless of the school district’s intention to bill for Medicaid-related school-based mental health services.

The packet serves a dual purpose. Section I is information for the district/educational service cooperative to submit as a Provider. Section II is to be completed for each individual practitioner working in the program. Consideration will not be given to incomplete applications and each must include original signature and dates.

|  |  |
| --- | --- |
| **SECTION I** | **DISTRICT INFORMATION** |

District Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Education Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Person for Program (Designated SBMH Coordinator)**

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicaid Billing Designee**

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caseload to be served**

K-12 Population

Preschool Population

ALE

Other:

**Frequency of Service**

Please offer information about providers and hours of service that will be provided on the school’s campus.

**Program Type (check all that apply)**

Employed MH Professional

Contracted MH Professional

Contracted MH Agency

**Crisis Services**

The AR Medicaid Manual states the provision of emergency services as 24 hours/7 days/12 months as noted in section 202.110 (https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/sbmh-prov/).

Please describe the plan to meet this provision.

**Service Location**

Describe the location of services at each building, along with plans to ensure confidentially of information.

**STATEMENT OF ASSURANCES**

The undersigned public education agency (school district/Education Service Cooperative), as a provider of School-Based Mental Health (SBMH) services approved to receive Medicaid reimbursement for services provided to the under age 21 Medicaid population, agrees to the following assurances in order to ensure quality and continuity of care:

**PROVIDER STAFF OR CONTRACTED PROFESSIONALS**: Employees or contractors engaged as Licensed School-Based Mental Health Practitioners will meet specific qualifications for their services. Furthermore, such practitioners will provide services only in those areas in which they are licensed or credentialed.

**SERVICES**: As a provider of SBMH services, the public education agency agrees to provide, either through employees or contractors, mental health services in a manner consistent with Section 202.110 of the Arkansas Medicaid Manual for SBMH services.

**LIABILITY INSURANCE**: Each practitioner will be covered by liability insurance.

**CONTINUITY OF CARE/SERVICES**: As a public education agency, we agree to work cooperatively with other providers of services to children and youth. Parental consent will be obtained, either by the public education agency prior to providing SBMH services. We further agree to work collaboratively to coordinate delivery of mental health services with other sources of similar services and care. We will make appropriate disclosure consistent with privacy and confidentiality rights of the treatment plan to all parties involved. This includes the sharing of “need to know” information between the public education agency and mental health provider, which may contain, but is not limited to the student’s diagnosis, social and behavioral functioning information, testing results, and familial information.

**NON REFUSAL REQUIREMENT**: As a provider of SBMH services, we will not refuse services to a Medicaid eligible recipient under age 21 in a school setting unless, based upon the primary mental health diagnosis, the provider does not possess the services or program to adequately treat the recipient’s mental health needs. SBMH services are available to any student in need regardless of Medicaid or third party eligibility.

**PHYSICIAN REFERRAL:** Recipients of services will be referred verbally or in writing for SBMH services by a Medicaid-enrolled physician as outlined in the Outpatient Behavioral Health system guidelines.

**COMPREHENSIVE ASSESSMENT**: Recipients of SBMH services will receive a documented comprehensive assessment before services begin.

**RECORD KEEPING:** All medical records that support the provision of medical services billed to Medicaid shall be completed promptly, filed and retained by the school district or ESC in which the child attends school. The records must be available for audit by Arkansas Department of Education, Division of Behavioral Health Services, and/or Arkansas Division of Medical Services (Medicaid).

**CONFIDENTIALITY**: All aspects of the SBMH services will comply with regulations regarding client privacy and confidentiality. Space for the delivery of personal client services will be guaranteed privacy and confidentiality. Records of all SBMH clients will be maintained in locked files and access will be regulated in accordance with confidentiality requirements.

**DOCUMENTATION:**  The public education agency will properly maintain prescribed written records for each child receiving SBMH services.

**RECIPIENT APPEAL PROCESS**: Upon receipt of an adverse decision, the recipient may request a fair hearing of the denial decision.

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Superintendent Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner of School-Based Mental Health Services Date

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Designated SBMH Coordinator Date

|  |  |
| --- | --- |
| **SECTION II** | **PRACTITIONER INFORMATION** |

The following items must be submitted by each practitioner in order to complete the ADE’s SBMH Certification process. Please return all of these documents with the Certification Application.

 **Current Resume of Practitioner**

 **Copy of Practitioner’s Current State License/Certification (showing expiration date)**

* **Practitioner’s Board Certifications** (If applicable)
* **Copy of Practitioner’s Diploma**

 **If Applicable, Current Professional Liability Face sheet** (must indicate applicant as the insured, policy period and coverage amounts with minimum limits of $1,000,000.)

 **Practitioner Profile**

 Explanation of any malpractice suits or licensing boards actions

Practitioner Profile

Name/Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: If “**YES**” is checked, please explain fully on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint and final disposition.

1. **Health Status:** Do you currently have any physical, mental, or emotional conditions which may impair your ability to render the professional services which are the subject of this application? ****YES ****NO

a. Do you currently use illegal drugs or abuse drugs or alcohol? ****YES ****NO

2. **Insurance Coverage:** Have you ever been denied professional liability insurance or initially refused upon application? ****YES ****NO

3. **License/Certification:** Has your professional license/certification in any state ever been revoked, suspended, placed on probation, conditional status, or limited? ****YES ****NO

a. Have you ever voluntarily surrendered your license/certification? ****YES ****NO

b. Are formal charges pending against you at this time? ****YES ****NO

4. **If Applicable: Hospital Privileges:** Has any hospital ever dismissed you from its staff? ****YES ****NO

a. Has any hospital ever revoked, suspended, or limited your privileges? ****YES ****NO

b. Has any hospital initiated either type of aforementioned action by formal notice to you? ****YES ****NO

c. Has any hospital refused or denied you privileges? ****YES ****NO

1. Have you ever voluntarily surrendered your hospital privileges?

****YES ****NO

5. **If Applicable: Hospital Sanctions:** Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? ****YES ****NO

6. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured? ****YES ****NO

7. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid? ****YES ****NO

8. **Criminal Offences:** Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? ****YES ****NO

1. Have you ever been named as a defendant in any criminal proceedings?

****YES ****NO

9. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board, certification board, county, local school board, state or national professional society, hospital medical or clinical staff? ****YES ****NO

10. **Malpractice Action:** Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgement(s) against you in a malpractice action? ****YES ****NO

a. To your knowledge, is any malpractice action against you currently pending?

****YES ****NO

b. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of $50,000 or more? ****YES ****NO

# **Attestation/Participation Statement**

I fully understand that if any matter stated in this application is or becomes false, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**district**) will be entitled to terminate my employment as a School-Based Mental Health Practitioner. All information that is being submitted by me in this application is warranted to be true, correct and complete.

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**district**) to consult with the State licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, hospitals, and professional references from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character, and moral and ethical qualifications. I also authorize all of them to release such information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**district**). I release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**district**) and its employees and agents and all those whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**district**) contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application to provide school-based mental health services.

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Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please Print)

***For assistance with this application, please contact:***

Beth Mathys, M.Ed.

School-Based Mental Health Coordinator

Division of Elementary and Secondary Education - School Health Services

Arkansas Department of Education

4 Capitol Mall, Room 305-B, Slot 14

Little Rock, AR 72201

Office: 501.682.5727

Cell: 501.813.0103

E-mail: [Beth.Mathys@ade.arkansas.gov](mailto:Beth.Mathys@ade.arkansas.gov)

OR

Elizabeth "Betsy" Kindall, Ed.D.

Arkansas AWARE State Project Coordinator

Arkansas Department of Education

Division of Elementary and Secondary Education

School Health Services

PO Box 610

Valley Springs, AR 72682

Office: 870.302.3094

Cell: 501.580.6827

E-mail: [Elizabeth.Kindall@ade.arkansas.gov](mailto:Elizabeth.Kindall@ade.arkansas.gov)

**Please mail completed application to:**

**The School Health Services Office**

**ATTN: SBMH Application**

**Four Capital Mall, Mail Slot #14**

**Little Rock, AR 72201**

# **Attachment C**

# **Site Visit Materials**

*Arkansas Department of Education*

School-Based Mental Health

Check List (Packet must contain all required information in order to be approved by ADE).

Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section I. District Program Information \_\_\_\_\_

1. Signed Statement of Assurance

Section II. Practitioner Information \_\_\_\_\_

1. Practitioner Profile
2. Practitioner Resume
3. Practitioner Licensure
4. Copy of Practitioner Diploma
5. Liability Insurance
6. Attestation Statement

Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendation: \_\_\_\_\_ Approve \_\_\_\_\_\_ Return

NOTES:

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Site Visit Checklist

(To be completed on site after submission as necessary)

Applicant(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School District and Provider

1. Review of Contracts, MOUs, Agreements (Specifics regarding sharing of confidential materials, fiduciary responsibilities, records, hours of operation, services etc. should be addressed)

a. HIPAA/FERPA \_\_\_\_\_\_\_

b. Record Keeping \_\_\_\_\_\_\_

c. Billing \_\_\_\_\_\_\_

d. Payments \_\_\_\_\_\_\_

e. Service Delivery Plan \_\_\_\_\_\_\_

f. On Call Plan \_\_\_\_\_\_\_

2. Tour of Facility (Counseling space, records, etc)

a. Space Committed for Services \_\_\_\_\_\_\_

b. Confidential Environment \_\_\_\_\_\_\_

c. Records on Grounds? \_\_\_\_\_\_\_

1. Fire Proof File Cabinet \_\_\_\_\_\_\_

2. Locked Files \_\_\_\_\_\_\_

3. Two Locked Doors \_\_\_\_\_\_\_

4. Access Limits \_\_\_\_\_\_\_

(FERPA/HIPAA) \_\_\_\_\_\_\_

3. Interview with Staff Partnership (District and Provider)

a. Administrative Commitment \_\_\_\_\_\_\_

b. Administrative Understanding \_\_\_\_\_\_\_

c. Administrative Cooperation \_\_\_\_\_\_\_

e. Provider Commitment \_\_\_\_\_\_\_

f. Provider Understanding \_\_\_\_\_\_\_

g. Provider Cooperation \_\_\_\_\_\_\_

4. Observation of Partnership Interaction

a. Open Communication \_\_\_\_\_\_\_

b. Problem Solving Approach \_\_\_\_\_\_\_

5. Partnership Integration

a. Assigned Staff \_\_\_\_\_\_\_

b. Multidisciplinary Staffings \_\_\_\_\_\_\_

c. Shared In-Services \_\_\_\_\_\_\_

d. Conference Attendance \_\_\_\_\_\_\_

6. Best Practices

a. One FT Therapist/Building \_\_\_\_\_\_\_

b. School-Based vs Linked \_\_\_\_\_\_\_

SBMH Site Visit Summary

**District/Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attendees: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Program Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Chart Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medicaid Billing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Areas for Improvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Site Review List**

|  |  |  |
| --- | --- | --- |
| School: | LEA: | **Date:** |
| **Medicaid #:** | **Reviewer:** |  |
|  |  |  |
| **Program Components (circle those offered)** | **Data Source for Review (circle those used)** |  |
| Individual Therapy | Policy & Procedure Manual |  |
| Group Therapy | Interviews with Administrators |  |
| Family Therapy | Interviews with Staff |  |
| Med Clinic | Interviews w/ Clinicians |  |
| Parenting Education | Treatment Record Review |  |
| Targeted Case Management | Case Management Record Review |  |
| Environmental Intervention | Tour of Facility |  |
| Crisis Intervention | Review of Safety Procedures |  |
| Other | Attendance at Staffing/Mtgs |  |
|  |  |  |
| **Answer each item by placing check in the YES cell if the indicator is satisfied – if it is not satisfied, leave the cell blank. If not applicable, mark the box with “N/A”. YES** | | |
| Are emergency services available on-site or by referral 24 hours/day, 7 days/wk? | |  |
| Are routine appointments available within 7 days? | |  |
| Are urgent appointments available within 48 hours? | |  |
| Are appointments for life-threatening emergencies available immediately? | |  |
| Does the program have policies and procedures for outside provider access? | |  |
| Does the program document staff education, licensure, and CEUs? | |  |
| Does the program retain a copy of license and resumes for mental health staff? | |  |
| Do formal procedures exist for diagnosis of problems, tracking resolution, and monitoring for improvement? | |  |
| Is student, parent/family, teacher satisfaction evaluated and reported on an on-going basis? | |  |
| Are there regular meetings with clinical staff, school staff and administration to review administrative and clinical policies, procedures and other issues? | |  |  |
| Are there program specific criteria in place for referrals, treatment and discharge? | |  |  |
| Does a multidisciplinary team provide assessment, treatment and support services? | |  |  |
| If multiple agencies are involved with the student, is there documentation of multi-agency service coordination or a multi-agency service plan? | |  |  |
| Do these agencies meet for case planning on a regular basis? Monthly or Quarterly? | |  |
| Are admission and treatment criteria consistent with interventions provided? | |  |
| Are student and family interviews conducted and documented? | |  |  |
| Is a comprehensive treatment plan completed within appropriate time frame for level of intervention? | |  |  |
| Is there evidence of active participation by students in treatment planning when possible? | |  |  |
| Does a formal system exist to assure follow-through on transition out of the program? | |  |  |
| Are treatment plans and progress reviewed every 90 days? | |  |  |
| Are support services provided and documented? | |  |  |
| Does the mental health program inform students and family of rights and responsibilities and grievance procedures? | |  |  |
| **Answer each item by placing check in the YES cell if the indicator is satisfied, if it is not satisfied, leave the cell blank. If not applicable, mark the box with “N/A”.** | |  |  |
| Do suicide prevention/precaution protocols exist?  Does the program have a policy addressing confidentiality and Notice of Privacy in accordance with HIPAA regulations? | |  |  |
|  |
| Are files containing any clinical information maintained in a locked and safe setting, in accordance with medical record privacy standards? | |  |  |
| Are treatment records up to date regarding signatures, releases and consents for participation? | |  |  |
| Are Medicaid Billing procedures followed consistently? | |  |  |
| Are areas where students are seen for counseling free from physical furnishings or equipment that represent a risk/safety hazard | |  |  |
| Does the program demonstrate the incorporation of cultural sensitivities into its treatment program? | |  |  |
| Is there a mechanism in place to gather data regarding school performance and mental health outcomes? | |  |  |
| Is there evidence of a summer program via protocol, attendance records etc.? | |  |  |
| Is there evidence of a parenting program via protocol, attendance records etc.? | |  |  |
| Does the partnership participate in Network Conferences and training opportunities? (Both school and mental health staff) | |  |  |
|  | |  |  |
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