Elizabeth Connors Resources

When to Refer a Student

Referral Form Example – UMB CSMH

Referral Form Example -- SSHS

Consent for Treatment – UMB CSMH

Release of Information to, from School   -- UMB CSMH

Release of Information to, from General Example -- SSHS

Release of Information to, from General Example – UMB CSMH

CSMHP Policies and Procedures Checklist, 508 Compliant

MTSS Memorandum of Understanding Example -- From CSMH

NSA School Based Mental Health Docs 11.29.17

Referral Feedback Form Template

Sample Memorandum of Agreement – From NRC SMH Module

School Wish List for Community Partner

SMH Referral and Triage – Direct Access Model

SMH Referral and Triage – Team Process Model

WHO SHOULD I REFER FOR MENTAL HEALTH SERVICES?

ANY STUDENT WHO YOU BELIEVE MAY NEED EXTRA SUPPORT

Here are a few issues to look out for:
Students who experience....

- **Depression/ Irritability**
- **Anxiety**
- **Oppositional behavior**
- **Poor peer relationships**
- **Withdrawal/Isolation from others**
- **Tendencies to harm self or others**
- **Family and/or community violence**
- **Academic and/or attendance problems**
- **Significant change in behavior or functioning**
- **Bereavement and loss**
- **Abuse and neglect**
- **Exposure to substance abuse**
- **Homelessness**
- **Family stress**
- **Bullying**
- **School refusal**
- **Low self-esteem**

Please use the attached form to make a referral. This could be the first step in making a difference in your student's life!

[SS/HS PROGRAM NAME HERE]

Confidential Referral Form

Student's Name: ____________________________ Date:__________________________

Grade:______ Home Room Teacher:______________________

Name of Referral Source:___________________________________

Pupil Identification Number (PIF #):____________________________

Race:____________________ Gender: (Circle) Male Female

Reason for referral:

(Please circle all that apply and write a brief description of your concerns)

Academic concerns Behavioral Concerns Attendance Concerns Social Concerns Emotional Concerns

____

____

____

____

____

Please include family/guardian contact information (if available):

Name of parent(s)/guardian(s): ____

Address:____

Phone numbers: Work: (____)______________________________Home: (_____)______________________

Cell: (____)_____________________________Other: (_____)_________________________

Please rate the urgency of this request:

not urgent moderately urgent very urgent

1 2 3 4 5 6 7 8 9 10

We appreciate your referral! Thank you!

(To be completed by receiving clinician)

Date Received: __________

Disposition:____

____

____

____

____

____

____

____

_______________ School District - SS/HS Initiative
School Mental Health Referral Form
CONFIDENTIAL STUDENT INFORMATION SHEET

Today's Date: _______________
Student's Name: _______________________________________ Social Security #: _______-______-_________
Parent Names: ____ _________________________________
(mother) (father)
Guardian Names: ____ _________________________________
(mother) (father)
Date of Birth: ____________________ Age: _______ Student ID #: ____________________________
Preferred Phone: (_______) _________________________ OK to leave message? __Yes ___No
Alternate Phone: (_______) _________________________ OK to leave message? __Yes ___No
Home Email Address: ______________________________ OK to leave message? __Yes ___No
Permanent Address: ____
Street City State Zip

Gender: __Male __Female Race ___________________
School: ____ Grade _______ Teacher _________________________

What is your health insurance provider? ________________________________ Other: ________________________
Medical conditions: ____
Please list any current medication (s): ____
____________________________ ____
Previous hospitalization or ER visit for mental health reasons: When?____________________________________
Why? ____
Past Interventions? ____
Reason for referral: ____
____
____

Please check all of the following items which are concerns at this time, and circle those which are most important.

Abortion issues	Fears, phobias	Picking fights with peers	Suicidal thoughts
Abuse – emotional, physical	Divorce, separation of parents	Pregnancy	Tiredness, fatigue
verbal, sexual, neglect	Grief issues	Racial/ethnic concerns	Trauma
Academic issues	Guilt	Repeated troubling thoughts	Violent thoughts
Alcohol use	Harassment	Relationship concerns	Withdrawal, isolating
Anger, arguing	Hallucinations	Relationship violence	Other concerns:
Anxiety, nervousness	Identity issues	Romantic relationship	
Behavior problems	Impulsive, out of control	Self-esteem issues	
Body image	Irritability	Self-injury, mutilation	
Compulsive behaviors	Intervention plan needed	Self-neglect, poor self-care	
Concentration	Learning disability	Sexual assault	
Decision making, indecision	Loneliness, no friends	Sexual concerns	
Depression, sadness, crying	Mood swings	Sexual harassment	
Drug use	Need testing	Sexual orientation/identity	
Eating problems	Parent deployment to war	Shyness, oversensitive	
Emptiness	Panic attacks	Smoking, tobacco use	
Family relationships	Perfectionism	Sleep problems	
Fearing failure	Peer relationship concerns	Stress	

____ Date _________________________________
Name/Signature of Person filling our Form

Your logo here, or use SS/HS logo, etc

[SS/HS PROGRAM NAME HERE]

In collaboration with (Partnering agencies/school system, etc here), the [SS/HS PROGRAM NAME] provides a full continuum of prevention and intervention services to [Your school system name here] elementary, middle and high school youth. Services through the SMHP include (update list below based on what is provided):

Individual Counseling

Group Counseling

Family Counseling

Case Management

Family Activities/Events

Classroom Presentations/Activities

School-wide Activities

Classroom Behavior Support

Teacher/School Staff Consultation

Mental Health Screening and Assessment

Home Visits (as needed)

Psychiatric Consultation

Advocacy

Attendance and Support at Team Meetings

Resource Sharing

[SS/HS PROGRAM NAME HERE]

Consent for Mental Health Services

I give consent for my child,_______________________________________, to receive mental health services through the _____(SS/HS PROGRAM NAME HERE)______ at my child's school. I understand that these services may include individual, group, and/or family sessions, teacher/staff consultation, as well as other services and activities (see attached). I understand that youth, teacher, and caregiver assessments will be collected as part of the school mental health program. These assessments will be used to inform treatment and to ensure the quality of the services provided. Results of these assessments will only be shared as a group report, without any identifying student information. All records pertaining to the school mental health services are the property of the school mental health program and will be kept confidential (i.e. they will not be released without parental/legal guardian permission). Please sign below to indicate your consent for your child to receive school mental health services from the (SS/HS PROGRAM NAME HERE).

Signature of parent/legal guardian	**Date**
Printed Name of parent/legal guardian	**Phone Number**
Address	**Work Number**
Therapist/Witness	**Date**

☐ **Please check if student is over 16 years of age.**

☐ **Please check if student is 18 years of age or older.**

[SS/HS PROGRAM NAME/LOGO HERE]

CONSENT FOR RELEASE OF INFORMATION

Student Name: _________________________________ Date of Birth ____________________________

Address ____

Home Telephone #: _______________________ Mobile Telephone #: ____________________________

Check and complete the appropriate section:

☐ As the parent/legal guardian of the above-named student, I, _____________________________, acknowledge that the student will receive services from [SS/HS PROGRAM NAME HERE] on-site at the student's home school.

☐ I, the above-named student, acknowledge that I will receive services from [SS/HS PROGRAM NAME HERE] on-site at my home school.

I authorize UPI to release to and receive from the XXX School System medical/school information (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to the Child Study Team and other student service teams, and written and verbal communication with school staff related to mental health intervention.

In addition, I authorize [SS/HS PROGRAM NAME HERE] to release identifying student information to [EVALUATORS OR FUNDERS WHO USE PROGRAM DATA] to support program accountability and quality improvement activities.

I understand that the Records will be released and received for the purpose of treatment and quality improvement activities.

[SS/HS PROGRAM NAME HERE], its employees, officers and medical staff are released from liability for the release of information in accordance with this consent.

Signature of patient or parent/guardian ______________________________________

Relationship to Student ______________________________________

Date ______________________________________

Witness ______________________________________

(*This consent is valid one year from the date of signature*)

SSHS Initiative, ____________________________School District, School Mental Health Program

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Name: _________________________________ **Date of Birth: _____________**

I hereby authorize SSHS SMH program at ________________________ School District to exchange protected health information below with these parties:

____

Requested information:
I authorize the exchange of the following types of records, created from _______ to _______: (date) (date)

___ Attendance (appointments scheduled and met; dates of service)
___ Treatment plan
___ Safety concerns (level of danger to self or others
___ Treatment summary
___ Alcohol and other drug use
___ Academic related issues
___ Billing records
___ Written mental health records
___ Other: _________________________________

The purpose of the Requested Use or Disclosure is:

___ At the request of the patient ___ For coordination of care
___ To address academic concerns ___ For medical assessment
___ Other: ____

I understand that:
1. My authorization of disclosure of this information can be revoked by providing a dated and signed written
revocation to _______________________. However, mental health information disclosed before the receipt of my written revocation may be used for the purposes state above.

2. This authorization applies only to the disclosure of mental health information which exists as of today.

3. Information disclosed to a health care provider or health plan, in accordance with my authorization, cannot be
Further disclosed by the recip8ient without my consent, unless otherwise authorized by law.

4. If the persons or entities who are authorized to receive the information are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.

5. Within the provisions of Mental Health Information Act, I have a right to review the mental health information contained in my record.

6. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment.

Expiration Date: This authorization expires in 60 days from today's date, or this earlier date:__________ ,
or when the following event occurs: ______________________________________

____
Signature of Student or Parent/Guardian Date

____ ____

Signature of Witness Date

[SS/HS PROGRAM NAME HERE] Medical Record#: _______________

Consent for Release of Information

Our practice will not release your health information without your permission, except as provided in our Notice of Privacy Practices.

I hereby authorize [SS/HS PROGRAM NAME HERE] to release/receive my medical information including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment.

Patient Name: ______________________________ DOB: ___________________

Address: __________________________________ SS#: ____________________

Telephone #: _______________________________

Covering record(s) for the period of ___________________ to _____________________
Date Date

Information to be released:

- ☐ Copy of health record
- ☐ History and Physical
- ☐ Other: _______________
- ☐ Abstract
- ☐ Discharge Summary
- ☐ Operative Report

(Note: A fee may be charge for copies of medical records)

Information to be: ___ released to ______ received from:

Program: ____

Address: ____

Telephone: ____

The information will be release for the following purpose(s):
______ Request of Patient ______ Treatment ______Insurance ______Other

The facility, its employees, officers and medical staff are release from legal responsibility or liability from the release of information in accordance with this consent.

Signature: _________________________________ ____________________
Patient or representative Date

Printed Name: ___________________________________ Relation: _________________

Two Page Form
Date updated: 1/1/2015

[SS/HS PROGRAM NAME HERE] Medical Record#: _________________

Consent for Release of Information

You may revoke this authorization at any time. See the [SS/HS PROGRAM NAME HERE] Notice of Privacy Practices for more information about revoking authorization.

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from [SS/HS PROGRAM NAME HERE] ***EXCEPT*** in the following circumstances:

- If the only purpose for providing you with a service is to obtain information to disclose to someone else, then you must authorize that disclosure in order to receive the service. (Example: physical examinations required to obtain certain types of licenses).
- If the services are related to research, you may be required to separately authorize the use or disclosure for your health information for the research. This applies only to your health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to others.

Comprehensive School Mental Health Program Policies and Procedures Checklist

Directions: Check below the policies and procedures that your school, district, or community mental health agency has in place. Then review the list again to identify those you don't have in place that are the highest priority for your program to develop or revise.

Policy Or Procedure	√ If You Have This in Place	√ If It's a High Priority to Develop or Revise This
Policy allowing community agency staff to provide services in the school*		
Procedure for identifying students who may need mental health services*		
Procedure for referring students for mental health services*		
Procedure for triaging students experiencing a mental health crisis*		
Procedure for providing ID badges to community agency staff who work in the school		
Procedure for community agency staff to sign in and out of the school campus		
Delineation of roles and responsibilities of community agency staff who work at the elementary, middle, and/or high school levels		
Procedure to document student/family follow through with mental health referrals		
Policy regarding when and for how long students can receive mental health services during the school day		
Policy regarding credentialing requirements for staff who work in schools		
Policy regarding supervision of community agency staff who work in schools		
Procedure for maintaining client records at the school or on a secure website		
Procedure for assisting students to enter the mental health/behavioral health system		
Policies related to the community agency's treatment team (e.g., treatment plan oversight)		
Policies related to intake, treatment, and treatment plans for students referred by the school		
Memorandum of agreement specifying the district's and the agency's roles and responsibilities in the program		
Policy for conducting staff background checks		
Policy for designating a staff member to serve as liaison with the other party (i.e., the school or mental health agency)		
Policy related to releasing information to and receiving information from students' medical records		
Information-sharing agreement outlining how the school and community agency will share information about students		
Liability agreements (e.g., liability insurance for school and agency staff)		
Consent-for-treatment policy		
Policies and procedures for reporting abuse and neglect (Note: these need to align with the federal policy and state guidelines)		
Confidentiality agreement, procedures, and protocols		
Policies on staff training (e.g., mental health awareness training for school staff, training on the school' code of conduct for community agency staff)		

* It is a good idea to have these policies and procedures in place at the outset of your program.

Memorandum of Understanding
between
XX Public School System and
[Community Partner School Mental Health Program Name Here]

The Parties of this Memorandum of Understanding (MOU) are XX Public Schools (XX) and **[Program Name Here]** (xxx), hereinafter collectively referred to as the Parties.

I. **Purpose:** The purpose of this agreement is to establish roles and responsibilities of the Parties to develop and implement a comprehensive school mental health system (CSMHS) that utilizes the strengths and expertise of school and community-partnered professionals.
CSMHS are defined as school-community partnerships that provide a multi-tiered system of mental health supports (MTSS) to support students, families and the school community. "Mental health services" include activities, services and supports that address social, emotional and behavioral well-being of students, including substance use.

II. **Roles and Responsibilities:** The Parties agree to the following roles and responsibilities.

a. Responsibilities of **[Program Name Here]**
   i. Actively participate in school mental health team(s) to support effective school-community collaboration that promotes:
      - *well-defined roles and responsibilities of team members (with structures in place to avoid duplication of efforts),*
      - *data sharing,*
      - *data-based decision making,*
      - *seamless services and supports across tiers,*
      - *integration of mental health and other academic supports*
      - *effective referral processes.*

   ii. Provide mental health screening, assessment and services, to include [customize services below]:
   Tier 1 - *Mental health promotion services and supports (Tier 1) are mental health-related activities, including promotion of positive social, emotional, and behavioral skills and wellness, which are designed to meet the needs of all students regardless of whether or not they are at risk for mental health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level.*

   - [ ] Universal mental health screening
   - [ ] Social Emotional Learning (SEL) activities
   - [ ] School climate activities

- ☐ Positive behavioral expectations and rules/Classroom management
- ☐ Bullying prevention
- ☐ Restorative Practices
- ☐ Mental health literacy for students
- ☐ Mental health literacy for families/caregivers
- ☐ Mental health literacy for teachers/school staff
- ☐ Teacher/staff consultation to promote mental health of all students

Tier 2 - *Selective services and supports (Tier 2) to address mental health concerns are provided for groups of students who have been identified through needs assessments and school teaming processes as being at risk for a given concern or problem. When problems are identified early and supports put in place, positive youth development is promoted and problems can be eliminated or reduced. Sometimes these are referred to as mental health "prevention" or "secondary" prevention services.*

- ☐ Progress monitoring of students identified as "at-risk" and those receiving services
- ☐ Social skills training/coaching
- ☐ Group therapy for students identified as at-risk of developing mental health problems
- ☐ Teacher/staff consultation for students identified as at-risk of developing mental health problems

Tier 3 - *Indicated services and supports (Tier 3) to address mental health concerns are individualized to meet the unique needs of each student who is already displaying a particular concern or problem and displaying significant functional impairment. Sometimes these are referred to as mental health "intervention" or "tertiary" or intensive services.*

- ☐ Progress monitoring of students identified with mental health problems and those receiving services
- ☐ Individual treatment for students with mental health problems
- ☐ Group treatment for students with mental health problems
- ☐ Family therapy to support students with mental health problems
- ☐ Psychiatric evaluation
- ☐ Case management
- ☐ Teacher/staff consultation for students identified with mental health problems and those receiving services

- Peer support/navigation services for students identified with mental health problems and those receiving services
- Family peer support/navigation support services for families of students identified with mental health problems and those receiving services
- Facilitate transitions to and from community agencies and programs (e.g., mental health providers, psychiatric hospitals and day programs, juvenile services, child welfare)

iii. For all of above services, utilize evidence-based services and supports*, as available. When evidence-based interventions are not available for intended population, selected interventions should be based on promising/best practices and should be evaluated for program impact.
** Evidence-Based Services and Supports are programs, services or supports that are based directly on scientific evidence, have been evaluated in large scale studies and have been shown to reduce symptoms and/or improve functioning. For instance, evidence-based services and supports are recognized in national evidence-based registries, such as the Substance Abuse Mental Health Services Administration (SAMHSA), National Registry of Evidence-based Programs and Practices (NREPP), Blueprints for Healthy Youth Development, and Institute of Education Sciences (IES) What Works Clearinghouse (WWC). A full continuum of evidence-based services and supports within a school includes mental health promotion, selective prevention, and indicated interventions*

iv. Collect and report data that documents [customize data elements below]:
   - Clinician productivity
   - Program and intervention impact on student/school psychosocial and academic functioning
   - Student/family satisfaction and engagement

v. Ensure the complete confidentiality of any and all identifying student and family information gathered in the performance of this agreement. The information gathered, used and developed shall not be provided to any other party without the express written approval of individual(s) authorized to give consent for release of information.

vi. Meet federal, state and local regulations required of community mental health providers, including those stipulated by the Health Insurance Portability and Accountability Act (HIPAA).

b. Responsibilities of XX Public School System:
   i. Identify school(s) for service that demonstrate readiness and a commitment to

hosting a community mental health provider to support a multi-tiered system of mental health support (MTSS)

ii. Identify district and school point of contact to facilitate successful integration of community mental health provider into school(s) and to address any concerns

iii. Provide confidential space in school(s) that includes access to a locked file cabinet and mechanism for communicating with families and other providers (e.g., phone, computer, internet access).

iv. Facilitate inclusion and active participation of community partners in school mental health teams that utilize best practices in teaming:
   - *Well-defined roles and responsibilities of teams and team members, with structures in place to avoid duplication of efforts*
   - *System to evaluate existing team structures, with existing team continuation and new establishment only as necessary*
   - *Overarching school shared purpose and shared goals ACROSS teams*
   - *Unique goals for distinct teams*
   - *Teams and team members understand and support each other's purpose and work*
   - *Teams and team members have a process/procedure to ensure frequent and consistent communication*
   - *Teams and team members address any confidentiality barriers to facilitate regular information sharing across and within teams*

v. Create data-based decision models and referral processes that promote early identification and intervention for students

III. **Funding Agreement**:

a. XX School System will pay [Program Name Here] the total sum of **XX** for Month/Day/Year to Month/Day/Year in order for [Program Name Here] to provide services outlined above.

b. Payments will be made in a bi-annual invoice reconciliation, which will include an invoice listing services performed.

IV. **Independent Contractor**:

a. In providing services to XX Public School System students, [Program Name Here] shall at all times operate as an independent contractor and shall have no authority to make any arrangements or incur any liabilities on behalf of the Board.

V. **Duration and Termination**:

a. This Agreement is for the period beginning Month/Day/Year to Month/Day/Year. Either party may terminate this Agreement for non-performance after first giving written notice of breach to the other party and an opportunity for the other party to cure the non-performance within fifteen (15) days of the receipt of written notice. Notice shall be deemed effective when delivered via certified mail to the following:

XX Public Schools
Address
City, State

And to

[Program Name Here]
Address
City, State

VI. Insurance and indemnification

a. [Program Name Here] shall purchase and maintain during the term of any resulting agreement:

i. Commercial General Liability Insurance of at least $5,000,000 combined single limit coverage written on an occurrence basis covering all premises and operations, and including Personal Injury, Independent Contractor, Contractual Liability and Products and Completed Operations. **The Board of Education of XX Public School System** and all of its agents and employees shall be names as an additional insured, which must be shown on insurance certificates furnished to XX Public School System.

ii. Worker's Compensation Insurance benefits as required by [Your State] law to include Employers' Liability coverage with limits of at least $100,000 each accident, $100,000 each employee disease, and $500,000 disease policy limit.

iii. Professional Liability Insurance with limits of at least $1,000,000 each occurrence and $3,000,000 aggregate.

b. [Program Name Here] shall indemnify and hold harmless the Board, its employees, servants, and agents against all liabilities, loss, charges and expenses, including court costs and attorney's fees, resulting from the failure of [Program Name Here], its employees, servants, and agents, to faithfully and competently perform its obligations hereunder or arising from or caused by [Program Name Here]'s provision of services.

VII. Whole Agreement:

a. This MOU contains the entire agreement between the parties with respect to the subject matter set forth herein, but may be modified with the written consent of both parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives.

___________________________ By: ____

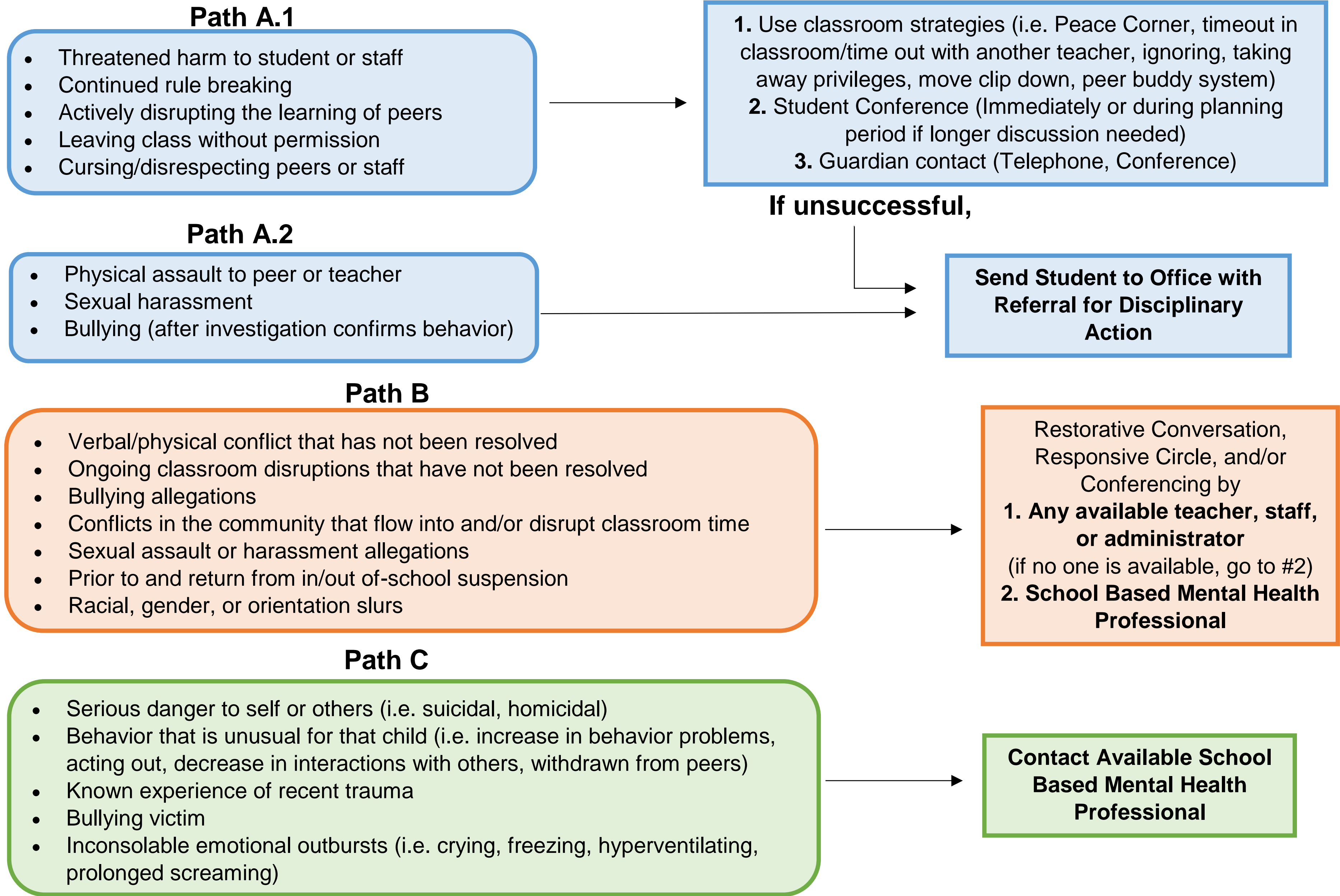
Superintendent
XX County Public Schools

___________________________ By: ____
Staff Attorney
XX County Public Schools

___________________________ By: ____
Supervisor of Finance
(Approved for Fund Sufficiency)
XX County Public Schools

___________________________ By: ____
Assistant Superintendent
XX Public Schools System

___________________________ By: ____
xx
Executive Director
XX Community Mental Health Agency



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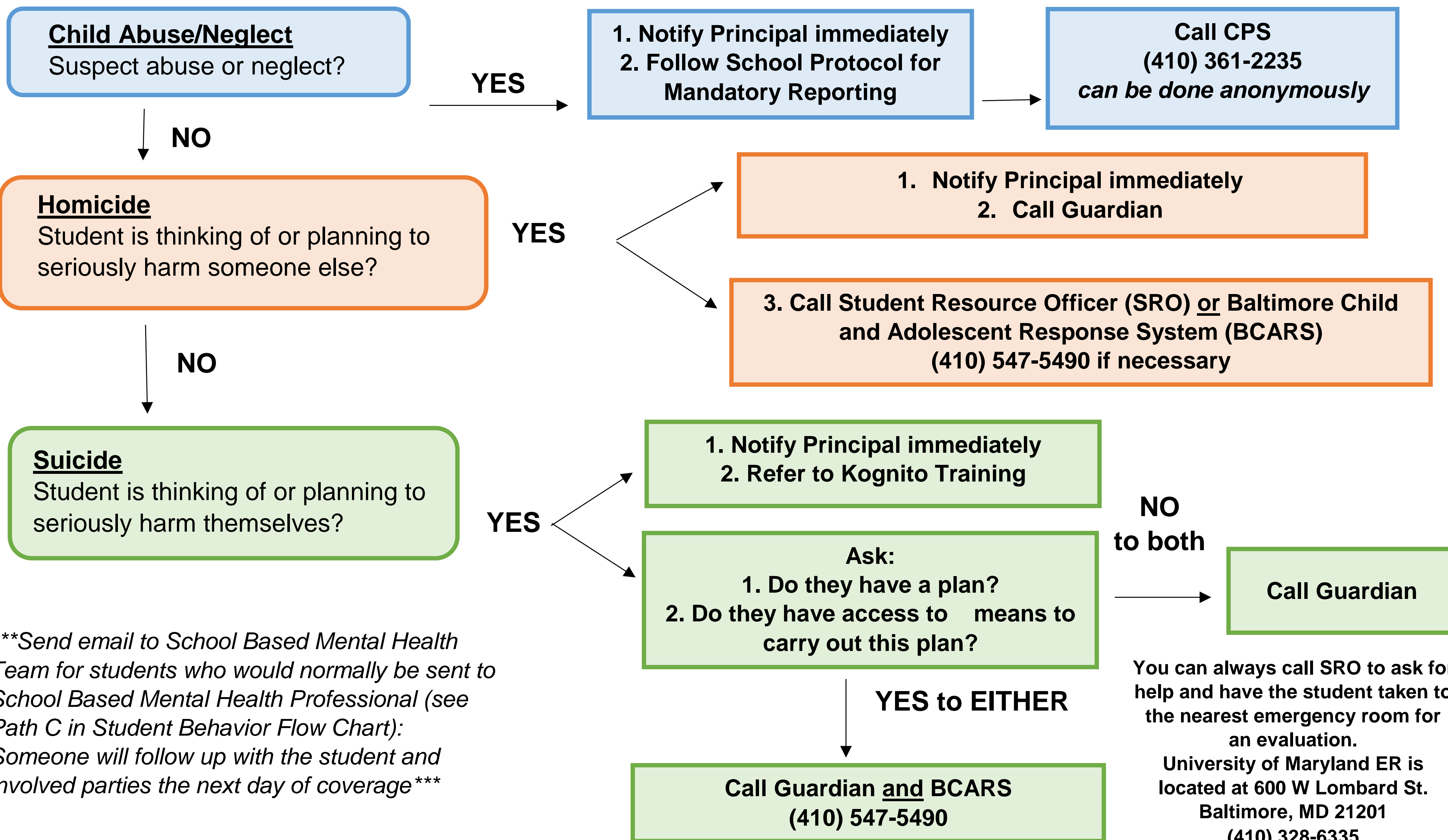
Crisis Protocol for Days of No Mental Health Coverage



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Roles of School Based Mental Health Professionals

A reference to better understand the roles of school based mental health professionals and the services they provide

Person/Position	Availability	Contact	Students Served	Unique Roles
*John Doe *Dean of Student Support*	Mon – Fri 9:30 – 3:30	johndoe@gmail.com	ALL	Provide student and staff support for restorative processes
Jane Doe, LCSW-C *BCPS School Social Worker*	Fri 8:30 - 3:30	janedoe@bcps.k12.md.us	All students, but must meet all outline IEP requirements (Can meet with any student 1-2 sessions before guardian consent)	Home-school-community liaison
Johnny Appleseed, Ed.S., NCSP *BCPS School Psychologist*	Fri 8:30 - 3:30	jappleseed@bcps.k12.md.us		Conduct psychological and academic assessments for IEP, individualized instruction and academic interventions, support student academic achievement **Services provided for 6-8 weeks*
Mr. Smith, M.A. *UM School Mental Health Clinician*	Tues 8:00 - 4:00 Wed 8:00 - 2:00 Fri 8:00 - 4:00	mrsmith@som.umaryland.edu (410) 645-0721	General education students with consent from guardian (Can meet with any student 1-2 sessions before guardian consent)	Prevention activities, early intervention, classroom observations and presentations, conflict mediation, medication management (with UM SMH Psychiatrist)
Mrs. Smith, B.A. *UM School Mental Health Extern*	Tues 8:00 - 1:30 Thurs 8:00 - 4:00	mrssmith@ubalt.edu		

**Not a Mental Health Professional and roles below do not apply*

Roles of ALL School Based Mental Health Professionals:

- Crisis intervention (i.e. danger to others or self)
- Assess emotional and behavioral disorders
- Provide evidence-based social/emotional/behavioral interventions for children and families
- Conduct individual, family, and group therapy
- Monitor student progress
- Provide classroom based supports with focus on positive coping skills in and outside the classroom
- Provide consultation services to staff, school teams, families to address behavioral concerns, attendance, and truancy
- Provide staff professional development
- Participate in school teams (i.e. IEP, Attendance, Champion Team)

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School Mental Health Program
Referral Feedback Form

To:_______________________________

From:_____________________________

Date:_____________________________

Regarding:_________________________

Thank you for referring the above student for school mental health services. The status of the referral is as follows:

______Was unable to contact parent or guardian

______Student/ family has not responded to appointment requests

______Student/ family declined counseling services: No consent provided

______Student was referred for outside evaluation /treatment

______Student is already receiving mental health services from another provider

______Student/ family has been reached, evaluation in progress to determine most appropriate services

______Consent forms were signed by the student/parent/guardian, services initiated

______Other:______________________

Comments:____

____

____

____

____

____

C. That the SM/BHCs will accept service referrals from the District's (insert role here) for assessment, treatment planning, and ongoing counseling/skill building services to be provided at the District-assigned facility.

D. That the SM/BHCs will each build a caseload of approximately 25-30 children during their assignment at the District facility. Actual caseload numbers will vary based on the severity of the mental health/behavioral health symptoms of the children served, but at no time will the caseload exceed 35 children per SM/BHC.

E. That the SM/BHCs will be capable of providing the following services (actual services provided will be based on the needs of the individual children referred to the SM/BHCs):
   - Intake and assessment of a child's mental and behavioral health symptoms/problems
   - Enrollment of the child in the Center's electronic medical record (EMR); all child EMRs are the exclusive property of the Center and information from a child's EMR can only be released to the District with proper authorization
   - Treatment plan formation
   - Provision of individual and group counseling
   - Provision of referral services to the Center's Child Mental Health Clinic
   - Provision of focused skill-building services for individuals and groups, including reducing maladaptive behaviors and teaching improved social skills and coping strategies
   - Crisis evaluation and intervention services
   - Consultation services for District-designated staff
   - Obtainment of parental consent for SM/BHCs to communicate with District-designated staff. This authorization will include permission to report to the District regarding the quantity and type of services received for grant purposes and for continuity of care between the Center and the District
   - Other services mutually agreed upon by the District and the Center

F. To cover the SM/BHCs and their services under its general liability/malpractice insurance policy.

G. To complete the data forms needed by the District for project monitoring, evaluation, and the coordination of services with other entities.

H. By no later than (insert date) to begin submitting billing requests to third-party payers for the services provided under this MoA that are eligible for reimbursement.

I. To invoice the District on a monthly basis for expenses incurred for services provided under this MoA. After (insert date), the Center agrees to subtract any fee revenue earned by services provided under this MoA from the incurred expenses to be invoiced to the District, prior to submitting the invoice for payment.

II. The District agrees:

A. To provide a base office space for each SM/BHC at (insert address) and to make available in each location where SM/BHCs are assigned to provide services a private space where SM/BHCs can meet with referred students, their families, and school personnel in a manner that insures the confidentiality of the information exchanged. This private space will be equipped in a manner that supports the use of a laptop computer and a small printer.

NATIONAL RESOURCE CENTER FOR
MENTAL HEALTH PROMOTION &
YOUTH VIOLENCE PREVENTION

Sample Memorandum of Agreement

Memorandum of Agreement Between (insert your school district's name here**)**
and (insert here the name of the mental health agency**)**

This agreement is entered into as of (insert date) between the (insert your school district's name here) (hereinafter referred to as "the District") and (insert here the name of the mental health agency) (hereinafter referred to as "the Center").

WHEREAS, the Center agrees to support the goals and objectives of (insert here the name of your Comprehensive School Mental Health Program); and

WHEREAS, the Center provides a range of services for persons experiencing symptoms of mental illness; and

WHEREAS, the Center provides outpatient mental health services to children and adolescents and maintains an outpatient clinic for that purpose at (insert the address of the outpatient clinic); and

WHEREAS, for the simplicity of language in this MoA the terms "child, children, and youth" include all children up to the age of 18; and

WHEREAS, the Center recruits and employs clinical staff who are trained to assess and provide counseling services to children who are experiencing mental health or behavioral health problems; and

WHEREAS, the District enrolls and provides educational services to children from the greater (insert the name of your county or catchment zone); and

WHEREAS, the District seeks to bring child mental health/behavioral health services into its school facilities to increase student and family access to such outpatient services; and

WHEREAS, the District seeks to increase its access to mental health/behavioral health consultation by having trained children's mental health/behavioral health professionals available in the District's selected campuses;

NOW THEREFORE, the Center and District agree as follows:

I. The Center agrees:

A. To hire and employ (insert number here) qualified Mental Health/Behavioral Health professional staff (who possess a master's degree in the social sciences and mental health/behavioral health counseling experience) who will be clinically supervised by the Center's (insert role here) who has a master's degree in the counseling field and is a state-licensed professional counselor. These staff will subsequently be referred to as School Mental/Behavioral Health Counselors (SM/BHC). These employees are the sole employees of the Center and have no employment relationship of any kind with the District.

B. To assign the above SM/BHCs to provide full-time services at the District-designated school facilities.

B. To give each of the SM/BHCs a District identification badge that provides the SM/BHCs with ready access and freedom of movement within the facility.

C. To make referrals to the SM/BHCs through the District's (insert role), who will be the primary communication conduit between the SM/BHCs and the District. The school counselors will attempt to obtain a release of information from the child's parent that would enable the information exchange needed between the SM/BHCs and appropriate District personnel.

D. To allow the SM/BHCs to attend appropriate District orientation, training, and coordinating meetings to enable the SM/BHCs to become familiar with the District's cultural and behavioral approaches to managing students with problem behaviors and to fostering a positive school climate.

E. To enable the SM/BHCs to have access to classrooms to observe the children referred to the SM/BHC in the classroom environment.

F. To give the SM/BHCs access to copying equipment so that they may copy documents needed for their records and reproduce materials for use with the children and families they serve and for use in providing consultation and training to District staff.

G. To give the SM/BHCs access to purchasing lunch in the school's cafeteria.

H. To reimburse Center invoices within 30 days of submission for payment.

I. To fund the costs involved with the placement of (insert number) SM/BHCs at District facilities from (insert date) through (insert date) according to the attached budget (Attachment A), with payments not to exceed (insert dollar amount) for the period of this MoA, unless the Center and the District mutually agree to amend this MoA to increase the maximum amount.

III. The District and the Center mutually agree:

A. That the term of this MoA shall be from (insert date) through (insert date) unless the Center and the District mutually agree to amend this MoA to modify the term.

B. That the District's (insert role) will serve as the District point person for coordinating the provision of services by the SM/BHCs.

C. That the SM/BHCs will be based at (insert name of the location), and will travel from that location to the school(s) that their assigned students attend. Each SM/BHC will have a primary school that the majority of his or her referred students attend.

D. The Center will purchase and maintain a laptop computer, air card, and inexpensive printer to be used by the SM/BHCs to access the Center's EMR system and to support documentation needs at the assigned locations. The District will reimburse the Center for these items as outlined in the budget in Attachment A.

E. To draft and sign student information exchange agreements within each organization's legal authority to do so.

F. To the extent permitted under the laws of the State of ________ to mutually indemnify and hold harmless the other organization, its trustees, officers, employees, and agents from and against all liabilities, claims, actions, expenses (including attorneys' fees and costs related to the investigation of any such claim, action, or proceeding), obligations, losses, fines, penalties, and assessments resulting from or arising out of the nonperformance or the negligent performance of the other party's obligations under this MoA.

G This MoA may be amended in writing at any time by mutual agreement of the parties to this MoA. Mutual assessment and evaluation of services shall occur during the period of this MoA and shall form the basis for decisions regarding the continuation and/or revision of services included in the MoA.

H. That either party to this MoA has the right to cancel this MoA for failure of the other party to perform in accordance with the terms outlined herein or in amendments hereto. If this MoA is cancelled for any reason, payment for services becomes payable within thirty (30) days from receipt of the final invoice or voucher submitted to the District. This MoA may be terminated by one party giving thirty (30) days written notice to the other at the address included herein.

I. This MoA shall be governed by and construed in accordance with the laws of the State of ________. This MoA document, with its attached budget, constitutes the entire MoA between the District and the Center. No additional terms or conditions shall become part of the MoA without the written consent of both parties and compliance with relevant state law.

J. That any written notice provided under this MoA or required by law shall be deemed to have been given and received when it is sent by registered or certified mail or hand-delivered to the other party of this MoA. The official recipients of such notices shall be as follows:

____

(insert here the name and address of the District recipient)

____

(insert here the name and address of the District's Assistant Superintendent)

____

(insert here the name and address of the Director or CEO of the mental health center)

NOW, THEREFORE, THE PARTIES TO THIS MOA DO AGREE TO ITS TERMS AND CONDITIONS AND SIGNIFY THEIR AGREEMENT WITH THE SIGNATURES BELOW:

________________________________	____________________________	______________
(insert here the name and title of the Superintendent of Schools)	Witness	Date
________________________________	____________________________	______________
(insert there the name and title of the Director or CEO of the mental health center)	Witness	Date

School or District "Wish List" for Community Mental Health Provider Services

This checklist can be customized by individual schools or districts to determine and rank by importance the key criteria they would like community mental health providers to meet in terms of services provided. Ideally, this checklist would be informed by input from students, families and the school team to reflect the unique strengths and needs of the school or district. Selected criteria can also be incorporated into a memorandum of understanding with the provider agency.

- ☐ Actively participate in school mental health team(s) to support effective school-community collaboration
- ☐ Provide mental health promotion (Tier 1) services and supports, to include [customize services below]:
  - ☐ Universal mental health screening
  - ☐ Social Emotional Learning (SEL) activities
  - ☐ School climate activities
  - ☐ Positive behavioral expectations and rules/Classroom management
  - ☐ Bullying prevention
  - ☐ Restorative Practices
  - ☐ Mental health literacy for students
  - ☐ Mental health literacy for families/caregivers
  - ☐ Mental health literacy for teachers/school staff
  - ☐ Teacher/staff consultation to promote mental health of all students
- ☐ Provide selective, "prevention" mental health services and supports (Tier 2), to include [customize services below]:
  - ☐ Progress monitoring of students identified as "at-risk" and those receiving services
  - ☐ Social skills training/coaching
  - ☐ Group therapy for students identified as at-risk of developing mental health problems
  - ☐ Teacher/staff consultation for students identified as at-risk of developing mental health problems
- ☐ Provide selective, mental health "prevention" services and supports (Tier 2), to include [customize services below]:
  - ☐ Progress monitoring of students identified as "at-risk" and those receiving services
  - ☐ Social skills training/coaching
- ☐ Provide indicated, mental health "intervention" or "treatment" services and supports (Tier 3), to include [customize services below]:
  - ☐ Progress monitoring of students identified with mental health problems and those receiving services
  - ☐ Individual treatment for students with mental health problems
  - ☐ Group treatment for students with mental health problems

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- ☐ Family therapy to support students with mental health problems
- ☐ Psychiatric evaluation
- ☐ Case management
- ☐ Teacher/staff consultation for students identified with mental health problems and those receiving services
- ☐ Peer support/navigation services for students identified with mental health problems and those receiving services
- ☐ Family peer support/navigation support services for families of students identified with mental health problems and those receiving services
- ☐ Facilitate transitions to and from community agencies and programs (e.g., mental health providers, psychiatric hospitals and day programs, juvenile services, child welfare)

☐ For all of above services, utilize evidence-based services and supports*, as available. When evidence-based interventions are not available for intended population, selected interventions should be based on promising/best practices and should be evaluated for program impact.

** Evidence-Based Services and Supports are programs, services or supports that are based directly on scientific evidence, have been evaluated in large scale studies and have been shown to reduce symptoms and/or improve functioning. For instance, evidence-based services and supports are recognized in national evidence-based registries, such as the Substance Abuse Mental Health Services Administration (SAMHSA), National Registry of Evidence-based Programs and Practices (NREPP), Blueprints for Healthy Youth Development, and Institute of Education Sciences (IES) What Works Clearinghouse (WWC).*

☐ Specialized training, certification, or services for ______________ specific student or school need identified

☐ Collect and report data that documents [customize data elements below]:

- ☐ Clinician productivity
- ☐ Program and intervention impact on student/school psychosocial and academic functioning
- ☐ Student/family satisfaction and engagement

☐ Regular professional development and/or supervision provided to school-based clinicians by the agency

☐ Strong focus on family partnership/ family involvement

☐ Ability to provide in-home or clinic-based services

☐ Highly recommended by parents and community members

☐ Able to bill both Medicaid and private insurance

☐ Experience working in schools/ familiarity with school climate and culture (e.g., briefer sessions, understanding of special education processes, etc)

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Place School District Name Here

School Mental Health Referral and Triage Flow Chart

DIRECT ACCESS MODEL

(Use when SMH providers are well integrated with one another in the school setting, and there is lots of communication among team members)

Student/Parent/Caregiver/School staff member completes **School-Based Mental Health Referral Form** and submits to the School-Based MH Provider (school or community-employed)

School-Based MH Provider who received the referral makes **contact with family and student** to get more information, better understand urgency, any special considerations to parent interest in services

Provider checks with SMH team* to confirm there is not duplication and to consider what interventions are already in place (ensure this process does not hold up scheduling intakes with families/moving forward with care, can be an informal process of checking in with SMH team members)

Relevant data are collected (including Special Education Services, academic and behavioral indicators, social emotional functioning) Based on referral and data, decision is made regarding provision of care (Tier 1, 2, 3)

Provider meets with family, consent to treatment received as appropriate, and considers how to integrate other school staff and interventions as appropriate and develops treatment plan. As appropriate – provider may **bring treatment plan process and progress to SMH Team*** to inform, integrate, and consult with them on care

*Family members should always be invited to team meetings and/or provided with follow-up about team member communication on student's referral/case

Date

Place School District Name Here

School Mental Health Referral and Triage Flow Chart

TEAM PROCESS MODEL

(Use when your school team prefers a heavily team-driven approach to mental health referrals AND you can identify a SMH Team Lead to be the "point person" for referrals received)

Referrals are given to any SMH Team Member (school psychologist, school social worker, community mental health provider, school administrator, behavioral specialist) who will bring to SMH Team Lead to process during a **SMH Team*** meeting

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Urgency of referral is assessed and immediate response is taken by SMH Team Member as needed if appropriate

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Referral is discussed at **SMH Team*** (within X number of days) and relevant data (including Special Education Services, academic and behavioral indicators, social emotional functioning) are collected

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Based on referral and data, **SMH Team*** decision is made regarding provision of care (Tier 1, 2, 3)

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A SMH provider will be identified to take the lead on the development of a student intervention plan that can be brought back to the team to update **SMH Team*** on progress at least twice per year

*Family members should always be invited to team meetings and/or provided with follow-up about team member communication on student's referral/case

Date