School Health Program
Five-Year Local Service
Plan Year: 2018-2023

COVER PAGE

County and District #:	
Name of District:	
Program Contact Name:	
Phone:	
Email:	

Please submit 1 original signature page. Electronic or scanned copies can be emailed to mathews_j@cde.state.co.us. Faxes will not be accepted. Be sure to read the entire Local Services Plan (LSP) Guidelines before submitting. LSP's must be submitted on the forms included in this document. BOCES must include an additional page that lists the names of member districts that are participating through the BOCES.

Due Date: Friday, June 8, 2018

Mail one (1) signed signature page to:

Jill Mathews
School Health Services Program
Senior Consultant
Colorado Department of Education
1580 Logan St.,
Suite 200
Denver, CO 80203

School Health Program
Five-Year Local Service Plan
Year: 2018-2023

SIGNATURE PAGE

Assurances

The signatures on this page assure the following as a condition of participation in the Medicaid School Health Services Program:

Each school district that chooses to enter into a contract as provided in this section shall develop a services plan with input from the local community that identifies the types of health services needed by students within the school district and the services it anticipates providing. Except for medical emergencies and services related to allegations of child abuse, a student's participation in any psychological, behavioral, social or emotional services, including counseling or referrals, shall be optional and shall require the prior written and informed consent of a parent or legal guardian of the student. 25.55318(4)(a)(I)

Any health questionnaire or form related to services funded in part through this section shall only relate to the student's personal health, habits or conduct and shall not include questions concerning the habits or conduct of any other member of the student's family. 25.55318(4)(a)(II)(A)

No medical or health data or information identifying the student or the student's family shall be disclosed to any person other than a person specifically authorized to receive the information or data without the prior written and informed consent of a parent or legal guardian of the student. 25.55318(4)(a)(II)(B)

Each school district that chooses to enter into a contract as provided in this section shall perform an assessment of the health care needs of its uninsured and underinsured students and may spend an appropriate portion, not to exceed thirty percent, of the federal moneys received on health care for low-income students. For purposes of this paragraph (b), low income students means students whose families are below one hundred eighty-five percent of the federal poverty level. 25.55318(4)(b)

Under the contract entered into pursuant to this section, a contracting school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.25.55318 (8) (a)

No moneys shall be expended in any form for abortions, except as provided in Section 26-4-512 or as required by federal law. 25.5-4-415

Where possible, the school district shall coordinate the provision of health services to a student with the student's primary care provider. Except for those services that are required by an individual educational program developed pursuant to Section 22-20-108(4), C.R.S., or by a Section 504 Plan developed pursuant to the federal "Rehabilitation Act of 1973", 29 U.S. C. Sec. 701, et seq., school district shall not claim reimbursement under this section for direct services to students enrolled in health maintenance organizations that would normally be provided to students by their health maintenance organization. 25.55318 (10)(b)

District/BOCES Medicaid Contact (please print)	School District/BOCES Name
Signature (must be signed in blue ink)	Street Address
Title	City/State/Zip Code
Date	Phone Number
Federal ID Number (FEIN)	
	Email Address

Please reference the attached Local Service Plan Guidelines for information on completing these forms.

School Health Program

Five-Year Local Service Plan

Year: 2018-2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Please use this form to describe the results of the Community Health Needs Assessment. Be sure to address all parts. If you need additional space, please use a separate sheet.

1. Briefly describe how you determined the health needs in your community (resources used, statistical information, key informants, etc.):

2. Describe what types of local health needs were identified in this process:

3. How did you gather input from **community members** about the health needs priorities in your district? (through meetings, surveys, phone calls, etc.):

4. Please list the prioritized health needs below:

5. How did you incorporate community input into your decision-making process and the development of funding priorities?

School Health Program

Five-Year Local Service Plan

Year: 2018-2023

UNINSURED/UNDERINSURED HEALTH NEEDS ASSESSMENT

Please use this form to describe the results of the Health Needs Assessment of Uninsured and Underinsured Students. Be sure to address all parts. If you need additional space, please use a separate sheet.

1. Describe the population considered uninsured or underinsured for purposes of the health needs assessment and how they were identified:

2. Describe how you determined what health services are needed by uninsured and underinsured students in your community? (What resources were used, statistical information, key informants, etc.):

3. Describe the types of health services needed by the uninsured and underinsured students as identified by the needs assessment process:

School Health Program

Five-Year Local Service Plan

Year: 2018-2023

COMMUNITY PARTICIPATION

School District/BOCES _____

In the table below, please list community members who provided input into the decision-making process. Include all information requested. If more room is needed, please use a separate sheet. Categories include but are not limited to the following:

Community Based Organization, Community Center Board, Community Members, Essential Community Provider, Group Home and Foster Care, Mental Health Providers, Migrant Programs, Parents, Probation and Parole Officers, Public Health, Public Housing, Refugee Programs, Religious Organizations, School Based Clinics, School-to Work Programs, Social Services, Students, Teen Parenting Programs, Transition Programs, Treatment Programs

Category	Name	Agency	Phone or email	Dist Emp? Y/N

				N
				N

School Health Program
Five-Year Local Service Plan
Year: 2018-2023

EXECUTIVE SUMMARY

1. School District/BOCES _____

2. Estimated yearly reimbursement **$** _____

3. Program Expenditures - list program expenditures by percentage in the table below:

2018-2019 LSP Expenditures by percentage	**Percentage**
Program Administration	
Health Services	
Total 2018-2019 Expenditures by percentage	0

PROGRAM PLAN

III-B-1 Administrative Plan

Total Administrative Percentages _____%

Please briefly describe administrative activities and percentages in the space below: **(Billing/Consulting Agent expense should be included here)**

School Health Program
Five-Year Local Service Plan Year: 2018-2023

Total Health Services Percentage _____%

Goal #: **1**		
Objective #: **1**		
Monitoring Plan:		
Percent of Total Health Services %	# Students Served	

Goal #: 2		
Objective #: 1		
Monitoring Plan:		
Percent of Total Health Services %	# Students Served	

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School Health Program

Five-Year Local Service Plan **Year:** 2018-2023

Goal #: 3		
Objective #: 1		
Monitoring Plan:		
	Percent of Total Health Services %	# Students Served

Goal #: 4		
Objective #: 1		
Monitoring Plan:		
	Percent of Total Health Services %	# Students Served

Goal #: 5		
Objective #: 1		
Monitoring Plan:		
	Percent of Total Health Services %	# Students Served

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School Health Program Five-Year Local Service Plan

Year: 2018-2023

Goal #: 6		
Objective #: 1		
Monitoring Plan:		
	Percent of Total Health Services %	# Students Served

Goal #:		
Objective #:		
Monitoring Plan:		
	Percent of Total Health Services %	# Students Served

Total Health Service Percentage: 0 **%**

Total # Students Served: 0

Types of services

For definitions, see the Local Service Plan Guidelines.

DS = Direct Service, IS = Indirect Service, OS = Other Service, SS = Subcontracted Service

School Health Program
Five-Year Local Service Plan
Year: 2018-2023

EXPENDITURES BY CDE CATEGORY (Required for state reporting purposes)

Health Service Category	Percentage
Assistance/Emergency Funds	
Assistive Technology	
Audiology	
Case Management	
Dental	
Health Assistant/Clinic Aide	
Health Education	
Health/Wellness Coordinator or Staff	
Intensive Health Tech	
Insurance Outreach - CHP+ & Medicaid	
Materials/Equipment/Supplies	
Mental Health	
Motor Therapy	
Nursing Services	
Nutrition	
Occupational Therapy	
Orientation & Mobility	
Parent/Family Services	
Physical Therapy	
Professional Development	
Physician Services	
Speech Language	
Screenings and Assessments	
Transportation	
Vision	
TOTAL CDE CATEGORY PERCENTAGE:	0

School Health Program
Five-Year Local Service Plan
Year: 2018-2023

SUPPLEMENTAL - SUBCONTRACTED SERVICES

Subcontracted Services

If any services will be subcontracted (for administration/billing agent or for health services) please provide the following information for each type of service:

1. The services being subcontracted (as listed in the Executive Summary).

2. The name of the subcontractor(s).