# Local Services Plan (LSP) Revision Companion Form

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| Information Needed | Response |
| **County and District #:** | <Enter County and District #> |
| **Name of District:** | <Enter Name of District> |
| **Program Contact Name:** | <Enter Contact Name> |
| **Phone Number:** | <Enter Contact Phone Number> |
| **Email Address:** | <Enter Contact Email Address> |
| **Revision Date:** | <Enter Date Sent to CDE> |
| **LSP Start Date:** | <Enter Start Date> |
| **LSP End Date:** | <Enter End Date> |

Important information about this LSP Companion Form:

* Be sure to answer all questions on this form.
* Incomplete companion forms will be returned to the submitter.
* There is **NO DEADLINE** for LSP revisions.

**To begin the LSP revision process, send the following documents to Andria Thornhill, Medicaid Consultant - School Health Services,** [**thornhill\_a@cde.state.co.us**](mailto:thornhill_a@cde.state.co.us)**, who will review & provide comments if needed:**

1. The revised District/BOCES Local Services Plan
2. A completed LSP Revision Companion Form (this document)

Please answer all questions starting on the next page.

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| 1. What is the reason for this Local Services Plan revision? |
| <Enter your response here. Please note, this box expands> |
| 1. Did your District/BOCES need to gather input from community members for this revision? If so, please briefly describe how community members were included in this process and what changes in community health needs were identified.   **Note:** This may be needed when LSP revisions are much different from prioritized or identified health needs outlined in the community sections of the original LSP (Part II-A & Part II-B). |
| <Enter your response here. Please note, this box expands> |

3. What areas of the LSP were impacted by this revision?

Enter an “X” for each section impacted by this revision:

\_\_\_\_ Part II – Community Health Needs Assessment

\_\_\_\_ Part III – Program Plan

\_\_\_\_ Part IV – Goals & Objectives