IN-SCHOOL COMMUNITY PARTNERSHIP FOR MENTAL OR PHYSICAL HEALTH SERVICES: ANNUAL FORM

This form should be completed by both the provider agency and the school. The agency must submit copies of licenses, a PS 115 F1-A Background Check Verification form, and evidence of liability insurance coverage for all service providers to the Office of Health Services, Department of Student Support Services.

If this is an initial application, it must be accompanied by PS 115 form F2. Check if initial or renewal: ☐ Initial ☐ Renewal*

(*attach copy of the Community Partnership Agency Report, PS 115 form F3 and Community Partnership School Report, PS 115 form F4, from prior year.)

Date: School Name:

School Year: 2017-2018 Principal:

Alternative Schools ONLY:
☐ Alternative School Partnership with Transition Services

AGENCY INFORMATION

Community Provider Agency Name:

Agency Phone Number: Agency Point of Contact:

Agency Address: Contact Telephone:

Contact E-mail:

Proposed Service(s) to provide on School Site:

☐ Physical Health Services

☐ Substance Abuse Services
- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Education

☐ Psychiatric Services

☐ Other Counseling Services
- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Family Counseling
- ☐ Referrals

☐ Other Services (specify):

Specify insurances accepted by agency:

List name(s) of service providers for this site (note: PS 115 F1-A Background Check Verification Form must be submitted to the Department of Student Services for each provider). If provider's name is listed differently on license (i.e. maiden name), please include both names below:

Name: Credentials:

Name of Supervisor:

The above-named agency and its employees agree to seek parent release for two-way exchange of educationally relevant information with appropriate school staff. Proposed services do not duplicate existing services or replace services on an IEP. Proposed services will not adversely impact the school instructional program. If staff changes during the year the agency will submit name, license, CJIS report and supervisor name to the Department of Student Support Services.

Agency Representative Name:

Agency Representative Signature:

Date:

SCHOOL INFORMATION

School Point of Contact (Name):

Contact Telephone:

Contact E-mail:

Space assigned:

Day(s) in school:

Resources to be provided, as feasible:

☐ Secure storage

☐ Telephone access

☐ Internet access

☐ Other:

Recommended by Principal: ☐ Yes ☐ No Principal Name:

Principal Signature: Date:

Submit this completed form to the Department of Student Support Services.

DEPARTMENT OF STUDENT SERVICES REVIEW

Approved: ☐ Yes ☐ No

Director, Department of Student Support Services Name:

Director, Department of Student Support Services Signature:

Date Approved: