# COVER PAGE

|  |  |
| --- | --- |
| **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> |
| **LSP Start & End Date:** | July 1, 2025 - June 30, 2030 |

Submit one (1) signed signature page (Part V – Signature Page) and one (1) completed Local Services Plan. Documents are found on the Colorado Department of Education’s (CDE) School Health Services (Medicaid) website. Electronic or scanned copies can be emailed to the contact below. **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. **Word (.docx) format is preferred for faster LSP processing.**

# Submit complete LSP and scanned Signed Assurances Page forms via email to:

Andria Thornhill, Medicaid Consultant - School Health Services

# thornhill\_a@cde.state.co.us

# Initial Review Due Date: Tuesday, June 17, 2025

# Final Submission Date: Tuesday, July 1, 2025

# COMMUNITY HEALTH NEEDS ASSESSMENT

This section covers the Community Health Needs Assessment results. Please address all parts.

|  |
| --- |
| 1. Briefly describe how you determined the health needs in your community (resources used, statistical information, key informants, etc.):
 |
| <Enter your response here. Please note, this box expands> |
| 1. Describe what types of local health needs were identified in this process:
 |
| <Enter your response here. Please note, this box expands> |
| 1. How did you gather input from **community members** about the health needs priorities in your district? (through meetings, surveys, phone calls, etc.):
 |
| <Enter your response here. Please note, this box expands> |
| 1. Please list the prioritized health needs below:
 |
| <Enter your response here. Please note, this box expands> |
| 1. How did you incorporate community input into your decision-making process and the development of funding priorities
 |
| <Enter your response here. Please note, this box expands>  |

# 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:
 |
| <Enter your response here. Please note, this box expands> |
| 1. 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.):
 |
| <Enter your response here. Please note, this box expands> |
| 1. Describe the types of health services needed by the uninsured and underinsured students as identified by the needs assessment process:
 |
| <Enter your response here. Please note, this box expands> |

# COMMUNITY PARTICIPATION

|  |  |
| --- | --- |
| **School District/BOCES:** | <Enter School District/BOCES Name> |

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)** |
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# PROGRAM PLAN

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| --- | --- |
| 1. **District/BOCES Name:**
 | <Enter School District/BOCES Name> |
| 1. **Est. Yearly Reimbursement:**

**(May vary year-over-year)** | <Enter Estimated Yearly Reimbursement> |
| Program Expenditures Overview |
| 1. **Program Administration:**
 | **<Enter Program Admin Percentage Here>** |
| Please briefly describe administrative activities in the space below: **(Billing/Consulting Agent, indirect costs, coordinator Salary/Benefits, and office supplies expenses should be included here)** |
| <Enter Response Here> |
| 1. **Health Services:**
 | **<Enter Health Service Percentage Here>** |
| Use the table below to indicate a plan to spend funds in each category and sub-category by marking “**X**” in the appropriate box. For example, if a district plans to spend funds to hire a Nurse, the district would indicate so by marking “**X**” under the column A “FTEs/Contracted Personnel” and row 1 “Nursing”. Additional guidance is found in the LSP Guidance document on CDE, School Health Services [webpage](https://www.cde.state.co.us/shs/medicaid_home). |

1. **EXPENDITURES BY CDE CATEGORY**

**(Required for state reporting purposes. Percentages NOT NEEDED. Mark chosen categories with “X”)**

|  |  |
| --- | --- |
| **Main Categories (Rows)** | **Sub-Categories (Columns)** |
| (A) FTEs & Contracted Personnel | (B) Equipment, Materials, & Supplies | (C) Professional Development & Trainings | (D) Screenings & Assessments | (E) Assistance & Emergency Funds |
| (1) Nursing |  |  |  |  |  |
| (2) Mental Health |  |  |  |  |  |
| (3) Student Health |  |  |  |  |  |
| (4) Special Service Providers |  |  |  |  |  |
| (5) Outreach & Enrollment |  |  |  |  |  |
| (6) Transportation |  |  |  |  |  |

|  |  |
| --- | --- |
| **Total Expenditure by percentage:*****Program Administration (A) + Health Services (B)*** | **100%** |

# GOALS AND OBJECTIVES

**Use the table *below the example table* to outline goals and objectives related to the spending of your School Health Services (Medicaid) reimbursement dollars.**

Goals and Objectives ***EXAMPLE TABLE***:

|  |  |  |
| --- | --- | --- |
| **Goal** | **Objective(s)** | **Monitoring Plan** |
| **(Example) Goal 1:** Address the needs of the disproportionately high number of students in XYZ School District by increasing Nursing services in the district. | **(Example) Objective 1:** Hire 2.0 FTE for Nursing Services.**(Example) Objective 2:** Increase Professional Development to support hired nurses in the district.**(Example) Objective 3:** Use funds to purchase supplies for the main nurse office as needed. | **(Example) Plan:** Purchases will be approved by the School Health Services Coordinator to ensure purchases are allowed. Use of funds will be documented on an Excel Spreadsheet to ensure timely submission of Reimbursement Spending Report to CDE. |

Use the table below to outline goals and objectives related to the spending of your School Health Services (Medicaid) reimbursement dollar. An example is provided on the next page for your reference. **Please Note:** Though there are only three (3) goals listed on the table, it is allowable to add more if needed. Table rows will expand automatically as needed.

| **Goal** | **Objective(s)** | **Monitoring Plan** |
| --- | --- | --- |
| Goal 1: <Enter Response Here> | Objective 1: <Enter Response Here>Objective 2:Objective 3: | Plan 1: <Enter Response Here> |
| Goal 2:  | Objective 1: Objective 2:Objective 3: | Plan 1: |
| Goal 3:  | Objective 1:Objective 2:Objective 3: | Plan 1: |