School Health Services Program
Five-Year Local Service Plan

COVER PAGE

County and District #:			
Name of District:			
Program Contact Name:			
Phone Number:			
Email Address:			
Start Date: (Year 1)		**End Date: (Year 5)**	

Please submit one (1) signed signature page (Part V – Signature Page) and one (1) completed Local Service 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 Estrada_O@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 documents (PDF and Word versions available). BOCES must include an additional page that lists the names of member districts that are participating through the BOCES.

If a signed assurance form has not been submitted for this period, please email one (1) Signature Page (Part V – Signature Page) to Omar Estrada, Estrada_O@cde.state.co.us.

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COMMUNITY HEALTH NEEDS ASSESSMENT

Please use this form to describe the results of the Community Health Needs Assessment. Be sure to address all parts.

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

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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:

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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)
				na
				na
				na
				na
				na
				na
				na
				na
				na
				na
				na
				na
				na
				na
				na

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PROGRAM PLAN

1. **District/BOCES Name:** _____
2. **Est. Yearly Reimbursement: (May vary year-over-year)** _____

3. Program Expenditures Overview

A. Program Administration:	0.00 %

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)**

B. Health Services:	0.00 %

Use the Expenditures by CDE Category table on the next page 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.

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C. EXPENDITURES BY CDE CATEGORY
(Required for state reporting purposes.
Percentages NOT NEEDED. Mark chosen categories with "X")

Health Service Category	Selected	Health Service Category	Selected
Assistance/Emergency Funds	☐	Nursing Services	☐
Assistive Technology	☐	Nutrition	☐
Audiology	☐	Occupational Therapy	☐
Case Management	☐	Orientation & Mobility	☐
Dental	☐	Parent/Family Services	☐
Health Assistant/Clinic Aide	☐	Physical Therapy	☐
Health Education	☐	Professional Development	☐
Intensive Health Tech	☐	Physician Services	☐
Insurance Outreach - CHP+ & Medicaid	☐	Speech Language	☐
Materials, Equipment, & Supplies	☐	Screenings and Assessments	☐
Mental Health	☐	Transportation	☐
Motor Therapy	☐	Vision	☐

Total Expenditure by percentage: ***Program Administration (A) + Health Services (B)***	0 %

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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 Annual Report to CDE.

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Plan Group: 2021-2026

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.

If you have questions, please contact Omar Estrada (Estrada_O@cde.state.co.us).

Goal	Objective(s)	Monitoring Plan
Goal 1:	Objective 1: Objective 2: Objective 3:	Plan:
Goal 2:	Objective 1: Objective 2: Objective 3:	Plan:
Goal 3:	Objective 1: Objective 2: Objective 3:	Plan:

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Use this page as a template if more goals/objectives are needed.

Goal	Objective(s)	Monitoring Plan
Goal 4:	Objective 1: Objective 2: Objective 3:	Plan:
Goal 5:	Objective 1: Objective 2: Objective 3:	Plan:
Goal 6:	Objective 1: Objective 2: Objective 3:	Plan: