Mental Health Intervention Team

**Program Application** (Forms)

**2020-2021**

**Forms to be submitted to KSDE**

**APPLICATION DEADLINE:** **JUNE 18, 2020**



*Kansas leads the world in the success of each student.*

Month Year

## **CHECKLIST - Grant application will include the following:**

1. **Mental Health Intervention Program Team (MHIT)** **Grant Request** (Form A)
The grant request includes the following information:
2. The number of school liaisons and buildings to be served by this program.
3. The number of students in each building to be served by this program.
4. The estimated cost of the salary and fringe benefits of the school liaisons in 2020-21.
5. The percent of students that qualified for free lunches in each building contained in the application based on the 2019-20 school year and the overall district’s free lunch percent.
6. The estimated number of foster students in each building contained in the application and the overall number of foster students in the district.
7. **Collaborative Agreement** between the USD and the CMHC or other mental health provider serving the district (signed).
8. **Explanation of Services and Need, items 1-6** Attach a written summary of each question.
9. **Program Assurances** signature page.
10. **Part 2: Applicant information** - This form provides contact information for the school district and the key point of communication on this grant.

**Instructions to electronically submit the grant application:**

1. Complete all forms (pg 3-8)
2. On the section “Explanation of Services and Need,” insert separate sheets for items 1-6
3. Print completed forms
4. Obtain signatures on Program Assurances and Collaborative Agreement
5. Place forms in the following order and scan to a pdf document:
* Form A. Grant Request for MHIT
* Explanation of Services and Need (Items 1-6 in order)
* Program Assurances (signed)
* Part 2: Applicant Information
* Collaborative Agreement (signed)
1. Rename the pdf document: **D0\_\_\_ FY21 MHIT Grant Request**

 D(zero)USD#

1. **Electronically submit to KSDE by 5 p.m. on June 18, 2020:**

Applicants are encouraged to submit early to avoid technical issues.

 **To**: craign@ksde.org ; vpeter@ksde.org

 **cc:** sroot@ksde.org

**Subj**: USD \_\_\_ FY21 MHIT Grant Request

 **Attach**: D0\_\_\_ FY21 MHIT Grant Request.pdf

**Program Questions****:** Craig Neuenswander, Director craign@ksde.org

Phone: (785) 296-3872 Veryl Peter, Program Consultant vpeter@ksde.org

**Memorandum of Understanding (MOU)**

Once the unified school district is awarded a grant, a **Memorandum of Understanding** must be submitted to KSDE, School Finance team, by September 30, 2020

A **Memorandum of Understanding (MOU)** is not part of this grant application, but will be submitted after the grant is awarded. This contractual agreement between the USD and mental health provider *must be signed and submitted to KSDE prior to receiving grant funds*.

Refer to the MHIT Guidance Document (pages 17-23) for a sample MOU document.

T:MHIT/2020-21 Grant Info/application info/MHIT forms to submit FY21

## **Form A.** Grant Request for Mental Health Intervention Team Program

|  |  |  |  |
| --- | --- | --- | --- |
| USD # |  | USD Name: |  |

 **Check one:** New USD [ ]  or USD previously in the program [ ]

**Below request new or additional school liaisons for the 2020-2021 school year:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | 2020-2021 | Number of School Liaisons Requested |
| Line | Account | Expenditure Accounts | Total Budget Request | FTE Full time  | FTE 1Part-time  |
| 1. | 2100 | 2 100 Salary |  |  |  |
| 2. | 2100 | 2 200 Employee Benefits |  |  |  |
| 3. |  | **TOTALS** |  |  |  |
| 4. |  | 3 Liaison Grant (75% of Line 3) |  |  |  |
| 5. |  | 4 Mental Health Provider Grant |  |  |  |
| 6. |  | **Total Grant Amount** (Line 4 + 5) |  |  |  |

 1 FTE full-time equivalency (to nearest tenth, i.e. 1.5)

 2 These amounts should be 100% of the school liaison’s 2020-21 estimated salary and employee benefits for the time spent in the MHIT program.

 3 This amount is the state grant portion of the MHIT program. The USD’s share is the remaining 25%.

 4 Line 5 cannot exceed one-third of Line 4**. Note: The mental health provider amount for the six 2018-19 pilot USDs shall be the greater of line 5 or the amount of the approved grant for 2019-20. If the USD Liaison Grant decreases in 2020-21, then the mental health provider grant will be prorated**.

**During the 2020-21 school year:** Will all attendance centers in the district be covered by School Liaisons hired for this grant? **Check one**: Yes [ ]  No [ ]

If no, please list the building(s) that will be served by School Liaisons in the MHIT program below during the 2020-2021 school year. Numbers are based on September 20, 2019:

|  |
| --- |
| ***List below only the attendance centers where school liaisons will be serving in the 2020-2021 school year and number of students*** ***I*** |
| Line | Building Name | 2019-2020Total number of Students | 2019-2020Percent of Free Lunches | 2019-2020Est. number of Foster Students |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |

**Insert sheet to list additional schools**

**During the 2019-20 school year:** What was the district percentage for students qualifying for free meals on September 20? \_\_\_\_\_\_\_ %

**During the 2019-20 school year:** What was the estimated number of foster students in the district? \_\_\_\_\_\_\_

**EXPLANATION OF SERVICES AND NEED**

**for the Mental Health Intervention Team Program**

The items listed below must be submitted in order for the USD to be considered for an MHIT grant.

1. Include a detailed explanation from the CMHC or other mental health provider of their capacity to provide services to the students, including case management personnel and clinical therapists, and a 24/7 crisis management plan providing services in the school buildings, and other services as designated in the Collaborative Agreement between the USD and mental health provider. (Attach a separate sheet.)

In addition, please list each of your mental health provider(s) and the amount negotiated for the services they will be providing. (sample below)

Name of Mental Health Provider Services to be Provided Dollar Amount of Agreement

1. A written summary of the need for this program based on such items as the estimated number of students needing mental health services, suicide/ideations data, and data from the CMHC on the need for the program for students in the district. (Attach a separate sheet.)
2. School liaisons hired by new USDs and current programs that are expanding must hire new staff. *Exception:* If current staff are used as school liaisons, the USD must have information on how the duties will change to meet the duties listed in Appendix A and how the old duties are being absorbed by their current or new staff members. Explanation of how the USD is handling duties, if an exception is being requested. (Attach a separate sheet.)
3. It is highly recommended to employ full-time liaisons. If part-time school liaisons are requested, the USD must have justification for designating time for duties of part-time school liaisons. Explanation of how the USD is going to provide documentation for part-time school liaisons.
4. Describe the collaboration with CMHC or other approved mental health provider of evidence-based mental health assessment, diagnosis, intervention, treatment and recovery through a multi-tiered system of supports and communication plan with the school district for this program. (Attach a separate sheet.)
5. (Attach a separate sheet.)
 State how the plan will establish policies and procedures for all schools, to ensure:
6. Students referred for a mental health screening to the mental health provider are assessed within 15 business days of referral;
7. Mental health services are initiated by the mental health provider within 15 business days of identification and assessment.

## MENTAL HEALTH INTERVENTION TEAM PROGRAM

## PROGRAM ASSURANCES 2020-2021

The signature page signed by the Superintendent and MHIT Program Coordinator/Director certifies the applicant’s agreement to the following sets of assurances.

*PLEASE READ COMPLETELY BEFORE SIGNING*

For the duration of the 2020-2021 performance period, the district shall:

* Use fiscal control and accounting procedures to ensure proper disbursement of, and accounting for, state funds paid to such applicants under this program.
* Submit reports as specified by KSDE and require School Liaisons to be trained on the Student Data System.
* Maintain records to substantiate program and funding compliance and afford access to such records as needed by KSDE .

|  |
| --- |
|  |
| USD Number and District Name |  |  |
| Signature of Superintendent |  | Date |
|  |  |  |
| Signature of MHIT Coordinator/Director |  | Date |

## MENTAL HEALTH INTERVENTION TEAM PROGRAM

## Part 2: Applicant information 2020-2021

|  |  |
| --- | --- |
|  |  |
| USD number | Name of School District |
|  |
| Mailing Address  |  |  |
|  |  |
| City | Zip Code |
|  |  |  |  |
| Telephone | Fax | Email address (superintendent or authorized rep) |
|  |  |
| Name of USD Superintendent **OR** Authorized Representative | Job Title |

**Complete the portion below for the Primary Contact Person (MHIT Coordinator/Director)**

* This person will be the key point of communication through the grant cycle:

|  |  |  |
| --- | --- | --- |
|   |  |  |
| USD number |  | Primary Contact Name |  | Job Title |
|  |
| Mailing Address |  |  |  |  |
|  |  |  |
| City |  |  |   | Zip Code |
|  |  |  |  |  |
| Telephone |  | Fax |  | Email address (primary contact person) |

## **MENTAL HEALTH INTERVENTION TEAM PROGRAM**

**COLLABORATIVE AGREEMENT 2020-2021**

### **Purpose of the Agreement:**

(Insert USD # and Name of School District) and (insert name of Community Mental Health Center/or other approved Mental Health Provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ have agreed to work together to provide treatment and track the behavioral health needs of youth enrolled in USD#\_\_\_\_\_\_\_\_\_. This agreement describes their understanding of and commitment to this collaborative effort.

### **Scope and Duration:**

This agreement will guide the collaboration for the period beginning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and ending June 30, 2021 USD # will hire and/or assign employees to the School Liaison position, to fulfill the roles and responsibilities outlined in the MHIT Program and School Liaison Guidance Document for School Districts.

(Insert Community Mental Health Center/or other approved Mental Health Provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will hire and/or assign employees to the Clinical Therapist positions, to fulfill the roles and responsibilities outlined in the MHIT Program and School Liaison Guidance Document for School Districts.

(Insert name of Community Mental Health Center/or other approved Mental Health Provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will hire and/or assign employees to the Case Manager positions, to fulfill the roles and responsibilities outlined in the MHIT Program and School Liaison Guidance Document for School Districts. In addition, the mental health provider will develop a 24/7 crisis plan to serve students.

Collaborative Agreement - Page 1 of 2

MENTAL HEALTH INTERVENTION TEAM PROGRAM

COLLABORATIVE AGREEMENT– page 2 of 2

(Insert USD # and Name of School District) \_\_\_\_\_\_\_\_\_\_ and (insert name of Community Mental Health Center/or other approved Mental Health Provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ will work together to meet the requirements of KSDE, including uploading student data in the database system and reporting requirements as outlined in the guidance tool. (Insert USD # and Name of School District) \_\_\_\_\_\_\_\_\_ and (insert name of Community Mental Health Center/or other approved Mental Health Provider) \_\_\_\_\_\_\_\_\_\_\_\_ agree to execute a Memorandum of Understanding (MOU) to establish an official partnership once the application has been approved by KSDE.

Each participating organization has agreed to commit resources for the collaboration and support of those employees hired to fulfill their requirements as outlined in the Guidance Document.

This agreement was adopted by designated representatives from (insert USD # and Name of School District) \_\_\_\_\_\_\_\_\_ and (insert name of Community Mental Health Center/or other approved Mental Health Provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/year). The signatures of the Superintendent of the School District and Executive Director of the Community Mental Health Center/or other approved Mental Health Provider below represent the interest and full commitment of their organizations to participate actively in the Mental Health Intervention Team Program.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Superintendent |  | Date |
|  |
| USD Number and District Name |  |  |
|  |  |  |
| Signature of MHIT Coordinator/Director for the Mental Health Provider |  | Date |
|  |
| Community Mental Health Center (or other approved Mental Health Provider) |