***INSTRUCTIONS:***

1. *Use this form to request long term shifts in school sites after following initial protocol for addressing low referrals.* ***BHCS contractors must receive approval prior to implementing shift of staff hours beyond the initial 3 weeks.***
2. *Completed form should be emailed to your assigned Program Contract Manager (PCM), also copying the COST Team Leads, Site Mental Health Leads and Principals of both schools and the District Mental Health Liaison.*
3. *Upon approval of your request, BHCS will request a revised agency budget that reflects the planned program changes, inclusive of FTEs, costs, number of units and mode of service rates.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Request** |  | Requester Name |  |
| Organization Name |  | **School Site Name** |  |
| **Organization Contact Name** |  | **Organization Contact Title** |  |
| **Organization Contact Phone** |  | **Organization Contact Email** |  |
| **COST Team Lead Name** |  | **COST Team Lead Email &****Phone #** |  |
| **Site Mental Health Lead Name**  |  | **Site Mental Health Lead Email & Phone #** |  |
| **District Mental Health Liaison Name** |  | **Unified School District** |  |
| **District Mental Health Liaison Email** |  | **District Mental Health Liaison Phone #** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Referral Problem Identified at Site** |  | **Requested Effective Date of Long Term Shift** |  |
| **Briefly Describe Referral Problem (reason, challenges implementing strategies to remedy situation, etc.)** |  |

|  |  |  |
| --- | --- | --- |
| **Requested site to Shift Funds FROM****“Existing Site”** | ***Address* (incl. +4 zip)** |  |
| ***Name of Current Principal*** |  | ***RU#*** |  |
| **Requested Site to Shift Funds** **TO****“New Site”*****Must be a currently contracted school site within the same school district.***  | ***School Site Name*** |  |
| ***Address* (incl. +4 zip)** |  |
| ***Name of Current Principal*** |  | ***RU#*** |  |
| **Requested Shift of Staff****(position(s) and number of FTE)** |  | **Staff and FTE at Existing Site after Shift** |  | **Staff and FTE at New Site after Shift** |  |
| **Requested Shift of Annual Hours of Service** |  | **Hours at Existing Site after Shift** |  | **Hours at New Site after Shift** |  |
| **Requested Shift of Annual Unduplicated Clients** |  | **Annual Clients at Existing Site after Shift** |  | **Annual Clients at New Site after Shift** |  |
| **Requested Shift of Monthly Average Caseload** |  | **Caseload at Existing Site after Shift** |  | **Caseload at New Site after Shift** |  |
| **Requested Amount to be Shifted** |  | **Amount at Existing Site after Shift** |  | **Amount at New Site after Shift** |  |

|  |
| --- |
| ***FOR BHCS USE ONLY*** |
| [ ]  **Approved**[ ]  **Not approved** | **System of Care Director or Designated Operational Lead** |  | Signature |  | Date  |  |
| *I have received this completed form and take responsibility for next steps to be completed according to established Network Office procedures. Next steps include:** *Confirmation of receipt to provider and obtaining Operational Lead approval – Program Contract Manager*
* *Report back to the provider around approval of their request – Fiscal/Program Contract Managers*
 |
| Program Contract Manager  |  | Signature |  | Date |  |
| **Fiscal Contract Manager(s)** |  | Signature |  | Date |  |
| Notes (for any special circumstances)  |  |