



School Based Behavioral Health Programs Shift of Funds Request

INSTRUCTIONS:

1. Use this form to request shifts in staffing and costs at school sites. Review information sheet for limitations. **BHCS contractors must receive approval prior to implementing shift of staff hours.**
2. Completed form should be emailed to your assigned Program Contract Manager (PCM). 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"	School Site Name				
	Address (incl. +4 zip)				
	Name of Current Principal		RU#		
Requested Site to Shift Funds TO "New Site" <i>Must be a currently contracted school site within the same school district.</i>	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

<input type="checkbox"/> Approved <input type="checkbox"/> Not approved	System of Care Director or Designated Operational Lead		Signature		Date	
<i>I have received this completed form and take responsibility for next steps to be completed according to established Network Office procedures. Next steps include:</i> <ul style="list-style-type: none">• <i>Confirmation of receipt to provider and obtaining Operational Lead approval – Program Contract Manager</i>• <i>Report back to the provider around approval of their request – Fiscal/Program Contract Managers</i>						
Program Contract Manager			Signature		Date	
Fiscal Contract Manager(s)			Signature		Date	
Notes (for any special circumstances)						