School-Based Behavioral Health Services

Are students in your classroom struggling with emotional or behavioral issues and in need of school-based behavioral health services?

Arizona Children's Association (AzCA) offers in-school services to your school, including:

- Behavioral Health Assessment
- Diagnosis
- Case Management
- Individual & Group Counseling
- Family Support
- Skills Training
- Psychiatric Services

Packets are available in the front office.

Packets include a School Referral Form and a Release of Information, allowing AzCA to reach out to the family.

Please contact us for additional information.

520.377.0843 Ext. 0

IntakesBH@arizonaschildren.org

We are Arizona's best resource for helping children and families!

For more information, visit us online at **www.ArizonasChildren.org**

ARIZONA'S CHILDREN ASSOCIATION

School-Based Behavioral Health Services
Referral Process

Referral:

- Your school makes contact with the family for a potential intake and provides the family with information on AzCA's services. Referrals can be made by student resource officers, school counselors, teachers, principals, staff and parents.
- If the family agrees to services, school staff will complete the AzCA Referral Form and have the family sign the Release of Information (ROI) .
- The Referral Form can be emailed to AzCA at BHreferrals@arizonaschildren.org or given to AzCA's Youth Engagement Specialist when they are on campus. The family can also call with questions or to schedule an intake at 520.377.0843 Ext. 0.
- AzCA staff will contact the guardian to provide information about the intake process and schedule the initial intake into services.
- Intake assessments will be conducted on school premises, at AzCA facilities, or at other sites based on the family's preference.
- Intakes are available to all students that are AHCCCS eligible. Students not eligible for AHCCCS may be screened for services under the Mental Health Block Grant. Those that do not qualify for services will be offered sliding fee self-pay services.
- AzCA's Youth Engagement Specialist will maintain ongoing communication with the school, including date of scheduled intake, CFT dates and any coordination of needs (must have guardian consent).

Following Intake:

- AzCA will provide a full array of services to children and families—behavioral health assessment, case management, psychiatric services, individual/group counseling, family support and skills training.
- AzCA's Youth Engagement Specialists will be available to the school to assist with coordination of services, resources, and collaboration with school staff to appropriately respond to behavioral health concerns or incidents on campus.
- AzCA's Youth Engagement Specialist will coordinate care with all outpatient providers and agencies for additional behavioral health support to students on the campus.
- AzCA's Youth Engagement Specialist will be available as a trauma-informed behavioral health resource to school staff (i.e. school counselors, assistant principals, teachers, etc.)
- With parental consent, AzCA staff will attend school IEP meetings or other intervention meetings between the school and parents.
- AzCA, upon request, will provide appropriate trainings to the school community.

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ARIZONA'S CHILDREN ASSOCIATION

School-Based Behavioral Health Services
Referral Form

Name of School:	**Date:**
Student's Name:	**DOB:**
Teacher's Name:	**Grade:**
Guardian/Caretaker's Name	**Guardian/Caretaker's Phone:**
Guardian/Caretaker's Address:	
Guardian/Caretaker's E-Mail:	**Are the Parents/Guardians aware of the referral?** ☐ **Yes** ☐ **No**
Reason/Concerns for Referral:	

Please send completed form to BHReferrals@arizonaschildren.org or call 520.377.0843 Ext. 0 for assistance.

FOR AZCA USE ONLY

Date Received: _____ **Date Contacted:** _____ **Date of Scheduled Intake:** _____

ARIZONA'S CHILDREN ASSOCIATION

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the use or disclosure of protected health information, as set forth below, consistent with Arizona and Federal Law concerning the privacy of such information. **Failure to provide all information requested will invalidate this Authorization.**

I hereby authorize Arizona's Children Association to disclose and/or exchange Protected Health Information (PHI) concerning:

Client Name: _____ to/with:

Authorized Recipient: _____
(Name, Organization, address, telephone number)

Purpose of the use or disclosure: _____

This Authorization applies to the following information (select only one of the following):

☐ All health information pertaining to my medical history, mental or physical condition and treatment received. {Optional} Except:_____

☐ Only the following records or types of information (including any dates): _____

_____

EXPIRATION

This Authorization expires (insert date): _____ or one year after date of authorization.

RIGHTS AND RESTRICTIONS

I understand that the Medical Care Provider will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I may refuse to sign this Authorization.

This Authorization may not be used to release Substance Abuse or HIV information in combination with any other health care information. Federal Law requires a specific Authorization to be used for the disclosure of this information.

This form may not be used to release psychotherapy notes in combination with other types of health information (45 CFR § 164.508(b)(ii). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other protected health information.

I may revoke this Authorization at any time, except to the extent that the Medical Care Provider already has taken action in reliance on the Authorization. My revocation must be in writing, signed by me or my guardian. My revocation will be effective upon receipt. I have a right to receive a copy of this Authorization.

I understand that, if information disclosed pursuant to this Authorization is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

Client/Parent/Legal Guardian Signature: _____ **Date: _____**

If signed by someone other than client, state relationship to client:

Witness Signature: _____ **Date: _____**