



**ST. MARTIN PARISH SCHOOL BOARD (SMPSB)
BEHAVIORAL HEALTH PROVIDER SERVICES
DURING THE SCHOOL DAY
APPLICATION & ACKNOWLEDGMENTS**

Delivered via: <input type="checkbox"/> U.S. Mail <input type="checkbox"/> In Person To: _____	
Other: _____	
Behavioral Health Provider Name: _____	
Address: _____ _____ _____	
Bus. Phone: _____	Cell Phone: _____
Parent Name & Address: _____	
Phone: _____	
Student Name: _____	DOB: _____
School: _____	Grade: _____

Date: _____

Pursuant to La. R.S. 17:173 and 3996(B)(45), I am seeking access to the above-referenced student on the premises of the identified SMPSB school facility during the school day for the purpose of providing needed behavioral health services identified through an appropriate behavioral health evaluation. In making this request:

- * I hereby attest and affirm that the parent/guardian of the above-referenced student (parent) has requested my behavioral health provider services (BHPS) and I have agreed to provide such professional BHPS to the identified student without limitations, consistent with federal and State laws, regulations, and La. Dept. of Health guidance, as well as SMPSB policies, procedures, and relevant directives.
- * I understand that: (1) this BHPS request; (2) the parent's written request/acknowledgment/consent for services; (3) the Consent to Release Information form signed by the parent; and (4) a copy of a behavioral health evaluation completed by me/a qualified behavioral health services provider **must be submitted by the parent to Adrienne Huval, representative of the St. Martin Parish School Board (SMPSB), at P.O. Box 1344, Breaux Bridge, LA 70517 or at adrienne_huval@saintmartinschools.org**.
- * I understand that I must meet the additional requirements required by law and SMPSB policies and procedures to access the student for BHPS during the school day.
- * I understand that the SMPSB will review this request and make a final determination about whether the parent and the behavioral health provider have met necessary requirements established by law and SMPSB policies and procedures, including appropriate licensing and insurance.
- * I understand that incomplete applications for the requested behavioral health provider services will not be considered for approval by the SMPSB.
- * I understand that I am not permitted access to the student on school premises unless and until

- written notice of approval provided by the SMPSB has been received by me.
- * I understand that my client is responsible for any and all costs associated with the BHPS delivered pursuant to this request.
 - * I attest and affirm that the student has received an appropriate behavioral health evaluation concluding that BHPS are necessary **during school hours** to assist the student with behavioral health impairments that I or other qualified behavioral health evaluator have determined are interfering with the student's ability to thrive in the educational setting.
 - * I understand that State law requires each student in grades 1-12 to receive a *minimum* of **360 minutes of educational instruction**, per day, for a minimum total equivalent of 167 days per school year. (Instructional time consists of scheduled time during the school day devoted to teaching core educational content and educational courses and experiences outlined in a program of studies approved by the Louisiana Department of Education (LDE)).
 - * I understand that the SMPSB provides its students with the required minimum of 360 minutes of educational instruction per day in accordance with State law and LDE requirements.
 - * I hereby acknowledge and understand that the BHPS that I may provide during the school day will deprive the student of the daily educational instruction time to which he/she is entitled by law and considered by the Louisiana Legislature and LDE to be necessary to facilitate student progress.
 - * I acknowledge and understand that the student's educational performance may decline due to repeated absences from class and/or occasions of tardiness during the school day resulting from the non-educational BHPS I seek to provide during the student's instructional day.
 - * I understand that while on a school campus, I am required by law to comply with, and abide by, the terms of any Individualized Education Program, Individualized Accommodation Plan, Section 504 Plan, Behavior Management Plan, or Individualized Health Plan applicable to a student who is my patient/client.
 - * I understand that I am prohibited from duplicating or superseding Medicaid-reimbursable services provided by the SMPSB and/or its assigns.
 - * I understand that my access and BHPS provided to the student on SMPSB premises is a privilege, not a right, and must conform to parameters established by the Superintendent and St. Martin Parish School Board, including procedural requirements more specifically detailed in a Memorandum of Understanding which I am obligated to sign as a condition of this application.
 - * I understand that violations of law and/or SMPSB policies and procedures may result in immediate denial of my access to the identified student and all other SMPSB students.

APPLICATION FOR BEHAVIORAL HEALTH TREATMENT OF MINOR AT SCHOOL

I certify that I understand the requirements for providing non-educational BHPS to a student on SMPSB premises during the school day and further acknowledge the potential negative impact on the student's educational performance resulting from missed instruction. I hereby request access to the student pursuant to parental request for such BHPS and my commitment to fully complying with all applicable federal and state laws and SMPSB policies and procedures and applicable guidance.

Behavioral Health Provider (PRINTED)

Behavioral Health Provider (SIGNATURE)

Date