

# Canyons School District – Mental Health Reimbursement Request Form

**Please send this completed form, along with required attachments, to:**

toni.cornay@canyonsdistrict.org

**Required attachments (do not submit this form until the following items are completed and attached):**

Preferred Provider Referral Form

Terrace Metrics Screener Results

The parent/guardian of the student listed below has requested to be referred to an approved mental health agency to receive assistance for their child regarding behaviors that are adversely impacting the health, well-being, and academic achievement of the child. The approved mental health providers supply these **limited services\*** at no cost to the family, after insurance and Medicaid, to students currently enrolled in a school in the Canyons School District. Funds for these services are provided through the CSD Foundation Grant.

**\*Limited services** refer to approved individuals for a limited amount of time (assessment and UP TO 6 SESSIONS), approved and determined by Canyons School District and mental health providers for treatment such as individual/group/family counseling, crisis intervention, and assessment. Services are based on the availability of funds through the CSD Foundation Grant. Services need to be initiated within 60 days of the date of referral noted below. Parent/Guardian will be responsible for any cancellation fees to the provider in the event they do not show up for a scheduled appointment.

Student Name:	DOB:  School:
Address:	City & ZIP:  Phone:
Parent/Guardian:	Relation: Phone:  Agency/Preferred Provider: Hopeful Beginnings Project Connections Other: _____
Therapist/Case Worker Name:	
The Preferred Provider Referral Form has been completed. A copy of the referral form has been attached to this request form to be submitted to Canyons School District, along with this form.	Circle Yes or No Yes No <b>(If no, stop here and complete the referral form before moving forward. Do not submit this form without the referral form attached.)</b>
Insurance? Yes  No	Are you willing to make a \$5 per session (\$35 total) donation to the Canyons School District Mental Health Support Fund? Yes  No <i>If yes, please ask the staff member who is completing this form with you for a copy of the directions for making this donation.</i>

<b>Reason for referral:</b>	<b>Previous interventions are documented in the SST Dashboard:</b>
Mental Health: _____	Yes
Behavior: _____	No (Reason: _____)
Other: _____	

**The school-level referring faculty member**, listed below, agrees that they have met with the student and parent/guardian(s) and have determined the

need for a Mental Health Referral, as noted above.

<b>School-level Referring Faculty Member Name:</b> Title: School:	
School Level Referring Faculty Member Signature: _____	Yes
Date: _____	<b>No (If no, stop here and complete the screener before moving forward.)</b>
<b>Do not submit this form without the screener results attached.)</b>	
The Terrace Metrics Screener has been completed.	
A copy of the results has been attached to this request form to be submitted to Canyons School District, along with this form.	

**The parent/guardian** listed above and below understands the limited services and agrees to participate. The parent/guardian also understands that the student's Terrace Metrics Screener results are required as a part of the Canyons School District Mental Health Funding Request process, and will be shared with all parties involved in this referral/request process. This form also serves as a release of information between Canyons School District and the Agency/Preferred Provider, as noted above.

**THIS FORM MAY NOT BE SUBMITTED WITHOUT WRITTEN PARENT APPROVAL. NO VERBAL APPROVAL IS ALLOWED. DO NOT SUBMIT WITHOUT THIS SIGNATURE.**

<b>Parent/Guardian Name (must match above):</b> Signature:	Date:
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<b>District Approval:</b> Name: Kelly Redican Title: Prevention Specialist	Signature:	Date:
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*Please provide a copy of this form to the parent/guardian for their records.* Revised: 07/31/2023

# Canyons School District – Mental Health Reimbursement **Round 2** Request Form

**Please send this completed form, along with the required attachment, to:**

toni.cornay@canyonsdistrict.org

**Required attachment (do not submit this form until the following is completed and attached):**

Updated Terrace Metrics Screener Results

The Therapist/Case Worker listed below has requested to continue **limited services\*** with the student listed below, who was previously approved for the first round of limited service through CSD Mental Health Funding. Based on the Therapist/Case Worker's professional clinical analysis of the named student's therapeutic needs and financial needs, approval for the second round of funding for these limited services is being requested. Funds for these services are provided through the CSD Foundation Grant.

**\*Limited services** refer to approved individuals for a limited amount of time (UP TO 6 SESSIONS), approved and determined by Canyons School District and mental health providers for treatment such as: individual/group/family counseling, crisis intervention, and assessment. Services are based on the availability of funds through the CSD Foundation Grant. Services need to be initiated within 60 days of the date of referral noted below. Parent/Guardian will be responsible for any cancellation fees to the provider in the event they do not show up for a scheduled appointment.

Student Name:	DOB: School:
Address:	City & ZIP:
Therapist/Case Worker Name:	Phone: <div style="text-align: right; margin-left: 100px;">Hopeful Beginnings Project Connections</div>
	Agency/Preferred Provider: <div style="text-align: right; margin-left: 100px;">Other: _____</div>
Therapist/Case Worker Phone Number:	Therapist/Case Worker Email:

**The Therapist/Case Worker** has assessed the named student's therapeutic progress and has determined that the named student requires additional mental health services. Therefore, the Therapist/Case Worker will begin additional sessions with the named student as soon as funding is approved.

**The Therapist/Case Worker** has assessed the family's current financial situation (including evaluating any updates to insurance coverage) and has determined that the family is unable to cover the cost of the sessions without the assistance of CSD mental health funding. Therefore, the Therapist/Case Worker is requesting a second round of CSD mental health funding for these additional limited services. The Therapist/Case Worker understands that CSD mental health funds can only cover up to 2 rounds of sessions, and the student/family should be transitioned to self-pay or outside resources after the second round of funding is complete. **A third round of funding will not be approved.**

**The Therapist/Case Worker** understands and has shared the information for the limited services with the named student and their parent/guardian. The Therapist/Case Worker also understands that the student's updated Terrace Metrics Screener results are required as a part of the Canyons School District Mental Health Funding Request process, and will be shared with all parties involved in this referral/request process.

This form also serves as a release of information between Canyons School District and the Agency/Preferred Provider, as noted above.

**The student listed above has successfully completed all sessions available through the first round of CSD mental health funding:** Yes  
 No (If no, stop here and complete all available sessions before requesting additional funding.)

The Terrace Metrics Screener has been re-administered to the student. A copy of the updated results has been attached to this request form to be submitted to Canyons School District, along with this form.

Yes

No (If no, stop here and complete the updated screener before moving forward. Do not submit this form without the updated Terrace Metrics screener results attached.)

<p><b>School-level Referring Faculty Member Name:</b></p> <p>Title:</p> <p>School:</p> <p><b>District Approval:</b></p> <p>Signature: _____ Date: _____</p> <p>Name: Kelly Redican Title: Prevention Specialist</p>	<p>Date:</p>
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