COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

SchooLink Annual Plan

To be used in conjunction with SchooLink Annual Meeting Agenda

School Name:	**SchooLink Provider:**
Date:	**School Year:**

1. School Liaisons

The **primary liaison** is responsible for answering referral questions from staff and caregivers and reinforcing the referral process.
The **secondary liaison** serves as backup if the primary liaison is unavailable.

Primary School Liaison (name/title):	
Email:	Phone:
Secondary School Liaison (name/title):	
Email:	Phone:

2. SchooLink Provider

Onsite Provider (name/title):	
Email:	Phone:
Provider's Supervisor (name/title):	
Email:	Phone:

3. School Access and Space

➢ What are the school access procedures?	
Parking:	Sign-In/Out:
After-School Hours:	Other:
➢ Where will the SchooLink provider meet with students?	
Primary:	Backup:
School Breaks:	
➢ Other Behavioral Health Resources/Providers on Campus: Behavioral Health Services (BHS) SchooLink Programs on campus: ☐ Skill Building SchooLink ☐ Core SchooLink ☐ Teen Recovery Center (TRC) SchooLink	
Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Provider? ☐ Yes ☐ No	
Contact Information:	
Services offered and how those services differ from SchooLink services:	

4. Referral Process:

➢ Who at the school can make referrals (for example complete and submit the referral form)?
☐ Counselor ☐ School Psychologist ☐ School Social Worker ☐ Nurse ☐ Teacher ☐ Other:
➢ Do all referrals need to be funneled through the primary liaison? ☐ Yes ☐ No
➢ How does the school log referrals? (Write "N/A" if not applicable)
➢ How will school referral forms be given to the SchooLink Provider?
☐ In-person to secure location (insert location):
☐ By secure fax to (insert fax number):
☐ Encrypted email (insert email address):
☐ Other:
➢ How should the SchooLink Provider handle urgent situations?

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Referral Process:		
Initial Contact	**Steps**	**Person Responsible**
Example: *Teacher, case manager, or parent will contact school counselor (A-L=Garcia; M-Z=Johnson)*	*1. School Counselor will get permission from caregiver & fill out referral form.* *2. School counselor will fax referral to SchooLink Provider office.* *3. Primary liaison will put referral in binder in principal's office after faxing the documents.*	*School Counselor*

5. SchooLink Monthly Communication Log:
SchooLink Provider will forward the monthly communication log by the (date) of the month.
➢ To whom should the monthly communication log from the SchooLink provider be forwarded?
☐ Primary Liaison ☐ Secondary Liaison ☐ Other:
➢ How should the communication log be delivered?
☐ In-person to secure location (insert location):
☐ By secure fax to (insert fax number):
☐ Encrypted email (insert email address):
☐ Other:
➢ How will the recipient of the log share the information with other referrers or school personnel?
➢ SchooLink Threshold Goals (Refer a minimum of 10 clients annually and have 5 active clients at all times):
Confirmed commitment:
If referrals are low, action school will take to address barriers:
If referrals are low, action SchooLink provider will take to address barriers:
➢ Review of Last School Year's SchooLink Threshold Data:
Total referrals for SchooLink services:
Total students provided SchooLink services on campus:
Barriers if thresholds not met:
What worked well and should continue?

6. Outreach Plan:
NOTE: In addition to the activities listed below, new outreach opportunities may come up during the school year. The School Liaison will inform the SchooLink Provider as these opportunities present themselves.

List the dates and times of **key school personnel meetings** that the SchooLink provider should plan to attend to increase awareness about SchooLink services (i.e. All-Staff Meetings, Student Study Team/Instructional Study Team (SST/IST) Student Meetings, or assemblies).

Date(s)/Time(s):	**Meeting:**

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List the dates and times of **key school personnel meetings** that the SchooLink provider should plan to attend to increase awareness about SchooLink services (i.e. All-Staff Meetings, Student Study Team/Instructional Study Team (SST/IST) Student Meetings, or assemblies).

Date(s)/Time(s):	Meeting:

7. Approved SchooLink Staff Schedules and Services:

Name/Title:	Role:	Days/Hours/ Contact	Eligibility (Insurance)	Services Provided	Caseload
	☐ Individual/Family Clinician ☐ Skill Building Group Facilitator ☐ Substance Use Disorders (SUD) Counselor ☐ Paraprofessional ☐ Other:	Days/Hours: Contact:			Current Caseload: Can see up to (number) students
	☐ Individual/Family Clinician ☐ Skill Building Group Facilitator ☐ Substance Use Disorders (SUD) Counselor ☐ Paraprofessional ☐ Other:	Days/Hours: Contact:			Current caseload: Can see up to (number) students
	☐ Individual/Family Clinician ☐ Skill Building Group Facilitator ☐ Substance Use Disorders (SUD) Counselor ☐ Paraprofessional ☐ Other:	Days/Hours: Contact:			Current caseload: Can see up to (number) students

Key School Support (counselor, social worker, psychologist, etc.)

Name/Title:	Days/Hours:	Contact Type:
Example: *Laura Smith, MSW, School Counselor*	*M/W: 9am-2pm*	*Email: Laura.Smith@appleusd.net* *Phone: 619-XXX-XXXX*

- NOTE: If key personnel or schedules change, please notify School Designee or SchooLink Provider accordingly.
- A copy of this worksheet was given to:

☐ School Principal or Designee ☐ SchooLink Provider ☐ Other meeting attendees, as applicable:

8. Notes

Additional Information/Comments:

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9. Meeting Participants					
SchooLink Provider		**School Staff**		**Other**	
Name	**Title/Role**	**Name**	**Title/Role**	**Name**	**Title/Role**