Alaska Resiliency in Schools for Educational Success

Program Information

The Department of Education and Early Development (DEED)'s Health and Safety team was awarded a $5 million five-year federal grant by the U.S. Department of Education to expand and deliver school based mental health services to students who are low income, academically struggling, and have experienced trauma.

The funding will enable DEED to oversee and facilitate a robust partnership between Fairbanks Community Mental Health/ Alaska Child Trauma Center, Fairbanks North Star Borough School District and private schools in the Fairbanks Borough to deliver school based mental health services.

The grants mission and purpose is to increase student wellness, adaptive student behavior, school safety and academic performance. In order to do this more effectively this grant will place a Mental Health Professional in your student's school to provide direct mental health services.

AK RISES hopes to establish/develop long-term partnerships between FNSBSD and public mental health providers so that:

- school-aged children and youth and their families can benefit from increased access to school-based universal prevention and
- early intervention services
- as well as off-site more intensive community-based mental health services will be provided.

Parental Choice

Services will be delivered by Fairbanks Community Mental Health/ Alaska Child Trauma Center Mental Health Professionals

- Parents will have the ability to choose a different provider who must:
  - Be licensed in the state
  - Offer secular, neutral, and non-ideological services as prescribed under this demonstration grant solicitation
  - Provide services that are consistent with those known to effectively treat trauma specific mental health conditions (training in trauma specific evidence-based treatment)

AK RISES Satisfaction & Wellbeing Survey

This satisfaction and wellbeing survey is a reporting requirement of the AK RISES grant. If your student is less than 12 years old and/or if you do not want your student to complete the survey, you will need to complete the survey from the perspective of your student. Otherwise, if your student is 12-17 years old, your written consent is **required** for your student to participate.

These are the survey questions excerpted from AK RISES Satisfaction Survey.

Satisfaction Survey (student completed) **How do you feel about the services you have received?**	Strongly Disagree  0	Disagree  1	Agree  2	Strongly Agree  3
I feel like I am listened to.	❍	❍	❍	❍
I feel I have a say in my plan.	❍	❍	❍	❍
I understand what I am working on with my provider.	❍	❍	❍	❍
I feel that my service provider understands me.	❍	❍	❍	❍
I receive the kind of services I think I need.	❍	❍	❍	❍
Overall, I am satisfied with the help I am receiving.	❍	❍	❍	❍

Satisfaction Survey (parent completed) **How do you feel about the services your child has received?**	Strongly Disagree 0	Disagree 1	Agree 2	Strongly Agree 3
The service provider listens carefully to what my child has to say	❍	❍	❍	❍
The service provider explains the plan for my child's treatment clearly.	❍	❍	❍	❍
The service provider understands my child's needs.	❍	❍	❍	❍
My child receives the kind of services I think he/she needs.	❍	❍	❍	❍
Overall, I am satisfied with the help my child is receiving.	❍	❍	❍	❍

These are the survey questions excerpted from AK RISES Wellbeing Survey.

Student Wellbeing Survey (completed by student) **How do you feel you are doing?**	Strongly Disagree  0	Disagree  1	Agree  2	Strongly Agree 

				3
I make friends easily.	❍	❍	❍	❍
My family gets along well together.	❍	❍	❍	❍
I like being in school.	❍	❍	❍	❍
When I have a problem, I can come up with lots of ways to solve it.	❍	❍	❍	❍
I think I am doing pretty well.	❍	❍	❍	❍

Student Wellbeing Survey (completed by parent) **How do you feel your child is doing?**	Strongly Disagree 0	Disagree 1	Agree 2	Strongly Agree 3
My child makes friends easily.	❍	❍	❍	❍
My family gets along well together.	❍	❍	❍	❍
My child likes being in school.	❍	❍	❍	❍
When my child has a problem, he/she can come up with lots of ways to solve it.	❍	❍	❍	❍
I think my child is doing pretty well.	❍	❍	❍	❍

Check only one of the statements below:

[ ] YES, my student is at least 12 years old and may participate in the surveys.

[ ] I will participate in the required surveys for my student.

Student's Name:_____Grade:_____

Parent/Guardian Signature:_____Date: _____

Alaska Trauma Recovery Grant in Schools Project DEED

I, _____Client _____ Parent ____Legal Guardian Herby Authorize Confidential Release of Information for

Client's Full Legal Name: _____ Birthdate: _____

Clients previous names:_____

The purpose of this *Release of Information* is for:
(check one or more, as applicable)

- ☐ Coordinate treatment: Treatment Planning: Continued treatment
- ☐ Billing and/or Payment of bill
  - ☐ Legal
- ☐ For Personal use
- ☐ Legal
- ☐ Other: (describe)

Type of information that may be shared:
(check one or more, as applicable)

- ☐ Mental or physical health information, regulated by HIPAA
- ☐ Educational Information regulated by FERPA
- ☐ Substance use information, regulated by 42 CFR Part 2 & HIPAA*
- ☐ Other: (describe)

Date range of information requested is between _____ and _____ .

Information may be exchanged …

- ☐ Verbally
- ☐ In writing

Specific Information That May Be Released Between Agencies/Individuals Identified Herein

Type of Info — Consenting parties should initial beneath the specific information to be released.

a. Personal	Name / Birthday	Phone	Address	Insurance	Other:
b. Mental Health	Attendance / Compliance	Assessment / Evaluation	Treatment Plans / Recommendations	Progress or Consultation Notes	Other:
c. Drug and Alcohol	Attendance / Compliance	Assessment / Evaluation	Treatment Plans / Recommendations	Progress or Consultation Notes	Other:
d. Educational	Attendance / Compliance	Grades and Achievement	IE or 504 Plan	Progress or Consultation Notes	Other:
e. Physical Health	Medical Reports / Diagnoses	Medications	Treatment Plans / Recommendations	Progress or Consultation Notes	Other:
f. Other					

Agencies or Individuals Authorized to Release and/or Receive Information

Agency or Individual's Name	Mailing Address	May receive information	May release information

(continued on page 2)

* Disclosed information related to substance abuse is protected by Federal confidentiality rules (42 CFR Part 2). These rules prohibit the further disclosure of information unless such disclosure is expressly permitted by written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Consent to this Release of Information

- I understand that I have the right to revoke this authorization at any time and that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that if I revoke this authorization I must do so in writing and present my written revocation to FCMHS Clinical Records at 563.1000.
- I understand that authorizing the use of disclosure of information is voluntary and that I do not need to sign this form to ensure health care treatment.
- I understand that if the person or organization receiving this information is not a health plan/health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient must continue to keep the information confidential.*
- I understand I have the right to receive a copy of this authorization form. I also understand that, upon my request, agencies signing this release must provide me with a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR 164.524, 42CFR Part2.
- I understand that the information released may include information regarding Psychiatric Treatment, Substance Abuse Treatment and/or HIV. If I have questions about disclosure of my health information, I can contact FCMHS Clinical Records at 563.1000.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand and agree to pay the costs incurred by FCMHS in preparing a copy of records I may request for myself as allowed by State and Federal guidelines

_____ **By initialing this section I am allowing the information to be disclosed one time. This authorization will expire 90 days from the date of my signature, unless otherwise indicated or revoked.**

Unless otherwise indicated or revoked this **authorization will expire 1 year from my signature date or in**: _____ days. (must be less than 12 months)

Client Signature (required by 42 CFR Part 2, except in specific circumstances)	Date Signed

Parent/Guardian Signature	Print Name	Date Signed
Witness Signature	Print Name	Date Signed

Copy must be offered to client: ___ Accepted ___Refused

SERVICE PROVIDER TO COMPLETE THIS SECTION			
ACTION TO BE TAKEN:			
☐ Send For Records	☐ Send ROI Only	☐ Release ACMHS/FCMHS Records	☐ File ROI Only

Revocation of this release of information: Date: _____ ___ Revoked verbally ___ Revoked in writing

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