



## **Alaska Resiliency in Schools for Educational Success**

### **Program Information**

**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.**

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.

<b>Satisfaction Survey (student completed)</b> 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I have a say in my plan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I understand what I am working on with my provider.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that my service provider understands me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I receive the kind of services I think I need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the help I am receiving.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Satisfaction Survey (parent completed)</b> 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The service provider explains the plan for my child's treatment clearly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The service provider understands my child's needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My child receives the kind of services I think he/she needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the help my child is receiving.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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



				3
I make friends easily.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family gets along well together.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I like being in school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I have a problem, I can come up with lots of ways to solve it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think I am doing pretty well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Alaska Trauma Recovery Grant in Schools Project DEED

## Confidential Release of Information

Name \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
(Name of client whose information is being released) (Optional)

Primary Address: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

Previous Name(s) \_\_\_\_\_  
(List any and all)

I, \_\_\_\_\_ Client \_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian hereby authorize

☐ Release Information To: ☐ Obtain Information From:

Name: Fairbanks Northstar Borough School District Phone# \_\_\_\_\_

Address: 520 Fifth Avenue Fairbanks, AK 99701 Fax# \_\_\_\_\_

The following information: ☐ written ☐ verbal

PURPOSE OF INFORMATION (Check box next to desired purpose)		INFORMATION TO BE RELEASED / REQUESTED (see next section for specific information)	
<input type="checkbox"/> Treatment Planning	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Mental or Physical Health Information, regulated by HIPAA	<input type="checkbox"/> Other: (describe)
<input type="checkbox"/> Continued Treatment	<input type="checkbox"/> Legal Use	<input type="checkbox"/> Educational Information, regulated by FERPA	<input type="checkbox"/> Date range of information requested is between _____ and _____
<input type="checkbox"/> Coordinate Treatment		<input type="checkbox"/> Substance use information, regulated by 42 CFR Part 2 & HIPAA*	

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

Type of Information		Consenting parties should check each box next to the specific information to be released.								
a. Personal	<input type="checkbox"/>	Name / Birthday	<input type="checkbox"/>	Phone	<input type="checkbox"/>	Address	<input type="checkbox"/>	Insurance	<input type="checkbox"/>	Other (describe):
b. Mental Health	<input type="checkbox"/>	Attendance / Compliance	<input type="checkbox"/>	Assessment / Evaluation	<input type="checkbox"/>	Treatment Plans / Recommendations	<input type="checkbox"/>	Progress or Consultation Notes	<input type="checkbox"/>	Other (describe):
c. Drug and Alcohol	<input type="checkbox"/>	Attendance / Compliance	<input type="checkbox"/>	Assessment / Evaluation	<input type="checkbox"/>	Treatment Plans / Recommendations	<input type="checkbox"/>	Progress or Consultation Notes	<input type="checkbox"/>	Other (describe):
d. Educational	<input type="checkbox"/>	Attendance / Compliance	<input type="checkbox"/>	Grades and Achievement	<input type="checkbox"/>	IE or 504 Plan	<input type="checkbox"/>	Progress or Consultation Notes	<input type="checkbox"/>	Other (describe):
e. Physical Health	<input type="checkbox"/>	Medical Reports / Diagnoses	<input type="checkbox"/>	Medications	<input type="checkbox"/>	Treatment Plans / Recommendations	<input type="checkbox"/>	Progress or Consultation Notes	<input type="checkbox"/>	Other (describe):

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\* 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.

# Alaska Trauma Recovery Grant in Schools Project DEED

(continued from page 1)

- 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 AKBH Clinical Records.
- 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 Part 2.
- 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 AKBH Clinical Records at 371-1300.
- 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 AKBH 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 for ANY substance use release)

Date

Relative/Guardian/Authorized Person

Printed Name

Relationship to Client

Date

Witness

Date

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 Alaska Behavioral Health Records

☐ File ROI Only

Only Complete this section at client request if ROI being revoked or no longer needed:

Revocation of this release of information:

Date: \_\_\_\_\_

     Revoked verbally      Revoked in writing

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