



I. GENERAL INFORMATION

| | | |
|---|---|-----------------------|
| District/Consortium | Mailing Address <i>Street, City, State, ZIP</i> | District No. |
| District Administrator <i>First & Last Name</i> | E-Mail Address | Phone <i>Area/No.</i> |
| SMHG Coordinator <i>First & Last Name</i> | E-Mail Address | Phone <i>Area/No.</i> |
| Community Mental Health Provider Partner | E-Mail Address | Phone <i>Area/No.</i> |

II. SMHS GRANT ACTIVITIES

Identify the major program strategies implemented through the expenditure of SMHS program grant funds. *Check all that apply.*

- | | | |
|--|--|--|
| <input type="checkbox"/> Mental Health Navigator | <input type="checkbox"/> Social and Emotional Learning | <input type="checkbox"/> Trauma Sensitive Schools |
| <input type="checkbox"/> Referral Pathway development | <input type="checkbox"/> Targeted Screening | <input type="checkbox"/> Universal Screening |
| <input type="checkbox"/> Mental Health Literacy/Adults | <input type="checkbox"/> Mental Health Literacy/Students | <input type="checkbox"/> Youth Mental Health First Aid |
| <input type="checkbox"/> Suicide Prevention | <input type="checkbox"/> Adult Staff-Care | <input type="checkbox"/> Collaboration and Coalition Development |
| <input type="checkbox"/> Collaboration and Coalition Expansion | <input type="checkbox"/> Co-facilitated Student Groups | <input type="checkbox"/> Student Guided Mental Health Activities |
| <input type="checkbox"/> Restorative Practices | <input type="checkbox"/> Initiated School-based MH Clinics | <input type="checkbox"/> Maintained/Expanded School-based MH Clinics |
| <input type="checkbox"/> Other <i>Specify:</i> | | |

If funds were used to support Mental Health Navigation, which activities were included: *Check all that apply.*

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Collect/Disseminate Referrals | <input type="checkbox"/> Maintain Records | <input type="checkbox"/> Follow up with Parents | <input type="checkbox"/> Assisting Families/Insurance |
| <input type="checkbox"/> Assisting Families in Scheduling and Getting to Appointments | <input type="checkbox"/> Liaison Between School and Community MH Providers | | |
| <input type="checkbox"/> Other <i>Specify:</i> | | | |

Did you purchase curriculum with SMHS Grant funds?

- No
 Yes *If yes, which curriculum(s) did you purchase? List all that apply.*

Will the district continue to implement strategies supported, in whole or in part, by this grant once the grant funding cycle ends?

- Yes, at a reduced level *Specify activities maintained:* *Specify Activities:*
 Yes, in full
 No

III. SMHS GRANT DATA COLLECTION

Provide the number of students in your district impacted, through grant funded activities, in each of the following categories.

| | |
|--|---|
| | Number of distinct students who received a mental health contact with a school mental health provider (School Social Worker, School Psychologist, School Counselor or School Nurse. Count a student only once even if they saw multiple people) |
| | Number of distinct students who received a mental health contact with a community mental health provider. (Count a student only once even if they saw multiple people) |

IV. SMHS GRANT EVALUATION

How would you rate your collaboration with your Community Mental Health Provider Partners?

- Excellent, our collaboration is significantly improving student mental health resources
- Good, our collaboration is making a difference but there is room to grow
- Emerging, our collaboration is fairly new but we have a committed group
- Struggling, our collaboration has hit some road blocks. *Explain:*

When you wrote your plan, in addition to collaborating with the CMHP, what was your primary objective:

To what degree was the primary objective met?

- Completely
- Partially
- Not at all

What data did you use to monitor your progress over the grant period?
Check all that apply.

What barriers did you encounter in attempting to evaluate program effectiveness? *Check all that apply.*

- Academic Achievement
- Office disciplinary referrals / violations
- Screening Data
- Survey data/Students
- Survey Data/Staff
- Survey Data/Parents
- Other *Specify:*

- Limited funding / resources
- Lack of support from community
- Lack of time / staff
- None
- Other *Specify:*

What was the most significant finding in review of the data or evaluation process undertaken to determine program effectiveness?

- AODA prevention / reduction
- Violence prevention / reduction
- Asset building
- Other
- School climate

V. SMHS GRANT FINAL REPORT NARRATIVE

Summarize the progress of your grant project. Include challenges and successes, any major changes to your plan and why those changes occurred. Also share any additional supports you feel are still needed to provide comprehensive mental health services for our students and families.

VI. CERTIFICATION SIGNATURES

Signature of Project Coordinator

Date Signed *Mo./Day/Yr.*



Signature of DPI Consultant

Date Signed *Mo./Day/Yr.*

