

Attachment B: School-Based Health Center Standards Self-Assessment and Site Visit Confirmation

Date: _____ Name of SBHC/School: _____ District : _____

Self- Assessment completed by: _____ Date: _____

Site Visit Representative: _____ Date: _____

Telephone number and E-mail Address: _____

A. Minimum, General School-Based Health Center Requirements		YES	NO	STATUS (Completed by DPH Staff on date of Assessment)	YES	NO
1.	<p>Documented proof of determination of need for a SBHC has been met. Examples:</p> <ul style="list-style-type: none"> a. Formal needs assessment or statement of need based on school data analyzed specifically for your center and discussed with the school board or governing entity b. Data on the % of students eligible for free and reduced meals c. School board approval for implementing a SBHC at the said site d. School board approval for types of services needing approval (examples): <ul style="list-style-type: none"> • Pregnancy testing • Diagnosis and treatment of STDs • Reproductive health • HIV testing and counseling e. Memorandum(s) of Understanding f. Contract with DPH g. Contract with School 					

Attachment B cont.: School-Based Health Center Standards Self-Assessment

A. Minimum, General School-Based Health Center Requirements cont.		YES	NO	STATUS (Completed by DPH Staff on date of Assessment)	YES	NO
2.	Written policies on: <ul style="list-style-type: none"> a. Consent for treatment b. Program and facility operations c. HIPAA and other confidentiality practices d. Billing practices e. Policy on Registration f. Quality Assurance g. Onsite services and connecting to other services not onsite or afterhours h. Communicable disease reporting to DHSS, DPH 					
3.	SBHC must display signage in accordance with school protocols that includes: <ul style="list-style-type: none"> a. the official SBHC name and sponsoring agency b. the SBHC room number c. the SBHC telephone number d. hours of operation e. SBHC services offered f. SBHC staff listed by name 					
4.	There must be at least one administrator responsible for the SBHC's overall management, quality of care and coordination with school personnel.					
5.	There must be a licensed physician that serves as the medical director of the site(s) and evidence of ongoing (at least quarterly) involvement of the medical director in clinical policy and procedures development, records review and clinical oversight.					

Attachment B cont.: School-Based Health Center Standards Self-Assessment

B. Environmental School-Based Health Center Requirements		YES	NO	STATUS (Completed by DPH Staff on date of Assessment)	YES	NO
1.	SBHC has adequate space to accommodate staff, patients, laboratory and clinical activities.					
2.	SBHC is in compliance with all building and safety codes.					
3.	<p>If there is an onsite laboratory, the SBHC is in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations for the type of lab tests performed:</p> <p>a. CLIA Certificate #: _____</p> <p>b. Expiration Date: _____</p> <p>c. Copy provided: _____</p>					
4.	<p>Although there may be differences in SBHCs from site to site and some rooms/areas are used for multiple purposes, the following must be present within the center:</p> <p>a. designated waiting/reception area</p> <p>b. at least one exam room</p> <p>c. at least one sink (hot and cold water)</p> <p>d. counseling room/private area</p> <p>e. toilet facility with a sink with hot and cold water</p> <p>f. office/clerical area</p> <p>g. secure storage area for supplies and medications</p> <p>h. designated lab space with sink and hot water</p> <p>i. secure and confidential storage areas</p> <p>J. phone line exclusively dedicated for the SBHC</p>					

Attachment B cont.: School-Based Health Center Standards Self-Assessment

C. Provider Service Center Information for Delaware SBHCs

List days of week and times of the day spent working at the SBHC. Be specific, (i.e. Monday 9a-4p and Thurs 1p-3:30p)

DAY	Hours	DAY	Hours
___ Mon.	_____	___ Fri.	_____
___ Tues.	_____		
___ Wed.	_____		
___ Thurs.	_____		

Name of the Provider: _____

Title of the Provider: _____

List days of week and times of the day spent working at the SBHC. Be specific, (i.e. Monday 9a-4p and Thurs 1p-3:30p)

DAY	Hours	DAY	Hours
___ Mon.	_____	___ Fri.	_____
___ Tues.	_____		
___ Wed.	_____		
___ Thurs.	_____		

Name of the Provider: _____

Title of the Provider: _____