School Health Services Provider Standards Self-Assessment and Site-Visit Confirmation

Name of Center/School: _____

District: _____

Address: _____

Contracted Entity: ☐ **Noncontracted Entity:** ☐

Self-Assessment Completed By: _____ **Date:** _____

Applicant Organization Contact: _____

Phone: _____ **Email:** _____

A. Minimum General School Health Services Center Requirements	Yes	No	Sponsor Comments	DPH Comments	Yes	No
1. Documented proof of determination of need for a Center has been met.						
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 low-income students or the % of students eligible for free and reduced meals.						
c. School board or governing entity approval for implementing a SBHC at the said site						
d. School board or governing entity approval for types of services needing approval: • Pregnancy testing • Diagnosis and treatment of STDs • Reproductive health • HIV testing and counseling						
e. Memorandum(s) of Understanding						
f. Contract with school						

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A. Minimum General School Health Services Center Requirements *(cont.)*	Yes	No	Sponsor Comments	DPH Comments	Yes	No
2. Written policies on:						
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. On-site services and connecting to other services not on-site or after hours						
h. Communicable-disease reporting to DHSS, DPH						
3. The Center must display signage in accordance with school protocols, which includes:						
a. Official Center name and sponsoring agency						
b. Center room number						
c. Center telephone number						
d. Hours of operation						
e. SBHC services offered						
4. There must be at least one administrator responsible for the Center's overall management, quality of care, and coordination with school personnel. a. If yes, please provide name and title.						
5. There must be a medical director at 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. a. If yes, please provide name and title.						

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B. Environmental School Health Services Center Requirements	Yes	No	Sponsor Comments	DPH Comments	Yes	No
1. The Center has adequate space to accommodate staff, patients, laboratory, and clinical activities.						
2. The Center is in compliance with all building and safety codes.						
3. If there is an on-site laboratory, the Center is in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations for the type of lab tests performed: a. CLIA Certificate #: _____ b. Expiration Date: _____ c. Copy Provided: _____						
4. Although there may be differences in health services per site and some rooms/ areas maybe used for multiple purposes, the following must be present within the Center:						
a. Designated waiting/reception area						
b. At least one exam room						
c. At least one sink (hot and cold water)						
d. Counseling room/private area						
e. Toilet facility with a sink (hot and cold water)						
f. Office/clerical area						
g. Secure storage area for supplies and medications, as well as a medical-grade refrigerator						
h. Designated lab space with sink and hot and cold water						
i. Secure and confidential storage areas						
j. Phone line exclusively dedicated for the Center						

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C. Provider Health Services Center Information

List days of the week and times of the day spent working at the Center.
Be specific (e.g., Monday 9 a.m. – 4 p.m. and Thursday 1 – 3:30 p.m.)

Day **Hours**

_____ Monday _____

_____ Tuesday _____

_____ Wednesday _____

_____ Thursday _____

_____ Friday _____

Provider Name: _____ **Email:** _____

Title: _____

List days of the week and times of the day spent working at the Center.
Be specific (e.g., Monday 9 a.m. – 4 p.m. and Thursday 1 – 3:30 p.m.)

Day **Hours**

_____ Monday _____

_____ Tuesday _____

_____ Wednesday _____

_____ Thursday _____

_____ Friday _____

Provider Name: _____ **Email:** _____

Title: _____

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D. Staff Listing

Staff Name: _____

Title: _____

Email: _____

Staff Name: _____

Title: _____

Email: _____

Staff Name: _____

Title: _____

Email: _____

Staff Name: _____

Title: _____

Email: _____

Staff Name: _____

Title: _____

Email: _____

Date Site Visit Completed: _____

School-Based Health Center Representative: _____ Date: _____

Delaware Division of Public Health Representative: _____ Date: _____