March 5, 2021

Mr. Kirby Smith, Superintendent

Campbellsville Board of Education

136 S. Columbia Ave.

Campbellsville, KY 42718

Brandy Close, Owner

The Kid SpOt Center, LLC

50 Gene Cash Road

Campbellsville, KY 42718

Dear Mr. Smith,

It has been a pleasure to serve the mental health counseling needs of the students in the Campbellsville School District over the last fouryears. Although this last year has been the most challenging we do hope that we were able to help in some manner ease the adjustments for the students. Enclosed you will find the contract for 2021/2022 school year. We do hope to discuss some alternate funding with you very soon but know that this contract needs to be placed on the agenda for a board meeting in order to be approved for next school year. Please reach out to me with any questions or concerns that you may have regarding the contract for school-based counseling services for next school year. Thank you, in advance, for the wonderful partnership.

Sincerely,

Brandy Close

Co-owner of The Kid SpOt Center, LLC

School Counseling Services Agreement

between

Campbellsville Independent Board of Education

and

The Kid SpOt Center

This agreements is entered into annually, between The Kid SpOt Center and Campbellsville Independent Board of Education, hereinafter referred to as “the school”.

1. TERMS

This agreement shall be in full force beginning on July 1, 2021 and shall be effective until June 20, 2022.

1. TERMINATION

Either party may terminate this agreement, with or without cause, at any time by giving at least thirty (30) days prior written notice to the other party of its intention to terminate this agreement.

Written registered or certified main shall deliver notice required under this agreement, postage prepaid, and return receipt requested, and addressed to the parties at the following addresses:

Campbellsville Independent Board of Education: The Kid SpOt Center:

Campbellsville Independent Board of Education The Kid SpOt Center

Attn: Superintendent Attn: Brandy Close

136 South Columbia Ave. 50 Gene Cash

Campbellsville, KY 42718 Campbellsville, KY 42718

1. OBLIGATIONS OF THE PARTIES

1. The Kid SpOt Center agrees to:
   * + 1. Provide therapists for the delivery of therapy services
       2. Provide an evaluation to determine need of counseling services
       3. Maintain open communication between The Kid SpOt Center, the child’s physician, school personnel, and others as permitted by parent/guardian through signed release of information.
       4. Participate in student care conferences of any type as requested by the school.
       5. Notify the school immediately of any unusual occurrences in a client’s treatment or any adverse change in a student’s condition.
       6. Provide a written list of students served by The Kid SpOt Center in the school counseling program if requested by school.
       7. Abide by all governing billing procedures as indicated in The Kid SpOt Center billing contracts with payer sources.
       8. Provide access to services based on severity of needs.  Clients who are clinically severe and in crisis will be seen as courtesy (no cost) visits regardless of ability to pay.  Potential clients with a financial barrier will follow the financial assistance plan.  Families meeting the financial assistance guidelines will receive services at a reduced rate or as courtesy visits.  If a current client needs continual care and insurance expires, the family will follow the “financial assistance” guidelines.  KSC will provide courtesy visits to a maximum of ten clients at any given time.
       9. As needed, schedule appointments at The Kid SpOt Center after school hours for students and/or families.
       10. Provide a certificate of liability insurance.

1. Campbellsville Independent School board agrees to:
   * + - 1. Provide a workplace/workspaces with phones and internet access for The Kid SpOt Center therapists that will be confidential in nature.
         2. Provide student availability for a minimum of five hours per day Monday-Thursday and three hours on Friday for a total of 23 billable hours per week per therapist.
         3. Participate in treatment planning as requested by The Kid SpOt Center.
         4. Therapy services will be provided as outlined below:

The school will identify students who may benefit from evaluation to determine if there is a need for counseling services.

The Kid SpOt Center will conduct the evaluation and determine if the student does have a need for counseling services.

The Kid SpOt Center will provide the recommended counseling services to the student if deemed necessary.

The Kid SpOt Center will work closely with the school staff to make the service collaborative.

* + - * 1. The school agrees to furnish The Kid SpOt Center with a certificate of liability insurance in the amount of $1,000,000

1. CONFIDENTIALITY

To comply with state and federal guidelines regarding confidentiality and HIPAA regulations, the school and The Kid SpOt Center agree to abide by the guidelines in The Kid SpOt Center confidentiality statement.  Any school personnel who may collaborate with The Kid SpOt Center on care of a student shall sign the agreement.

1. MEDICAL RECORDS

The school and The Kid SpOt Center acknowledge and agree that all medical records compiled while performing therapy services shall be property of The Kid SpOt Center.  The parties agree to comply with all state and federal guidelines governing the release of the medical records.  The Kid SpOt Center and Campbellsville Independent Schools have entered into a Memorandum of Understanding in order to release information to each other regarding patients and their care. (See attached document)

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the day and year first above written.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Kid SpOt Center

BY: BRANDY CLOSE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campbellsville Independent Board of Education

BY: SUPERINTENDENT

The above signatures were witnessed this \_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_, 20\_\_\_ by,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness

MEMORANDUM OF UNDERSTANDING (MOU)

This Memorandum of Understanding between **Campbellsville Independent Schools** and **The Kid SpOt Center, LLC Division of Behavior Supports,** dated this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_, represents an agreement by both parties to follow the requirements set forth below.

It is mutually understood that **The Kid SpOt Center LLC** shall provide all required services when a patient is referred for treatment services.

If during the course of treatment, a patient demonstrates a need for service at a different level of care, or if a client requests transfer to another program **Campbellsville Independent Schools** shall refer the client to an eligible program for the required services, and notify **The Kid SpOt Center, LLC Division of Behavior Supports** of such action.

If during the course of treatment, a patient is non-compliant, **Campbellsville Independent Schools**, shall notify **The Kid SpOt Center, LLC Division of Behavior Supports**.

It is the intent of both parties to keep each other informed regarding the services provided to the client. **Campbellsville Independent Schools** agrees to release copies of the records pertinent to the client's treatment to **The Kid SpOt Center, LLC Division of Behavior Supports**.

Both parties agree to comply with all applicable federal and state confidentiality requirements concerning the release of records.

**The Kid Spot Center, LLC**                      **Campbellsville Independent Schools**

Program Name #1           Program Name #2

50 Gene Cash Road\_\_\_\_\_\_\_\_\_\_\_\_\_ 136 S. Columbia Ave.\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Address

Campbellsville, Ky. 42718\_\_\_\_\_\_\_\_\_ Campbellsville, Ky. 42718 \_\_\_\_\_\_\_\_\_\_

City, State Zip City, State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_           \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-owner Signature         Administrator Signature