Second Wind Fund

YOUTH SUICIDE PREVENTION

https://thesecondwindfund.org/

SECOND WIND FUND has a mission to decrease the incidences of suicide in youth by removing financial and social barriers to treatment. To be considered for a referral by Second Wind Fund, the child or youth must be:

- 19-years-old or younger
- At risk for suicide
- Experiencing financial or social barriers to accessing therapy
- New to Second Wind Fund (has not utilized covered sessions from SWF before)

WAYS WE CAN HELP

1. SWF covers the cost of ***12-20 sessions of therapy*** with a SWF network provider
   - Youth initially receive 12 covered sessions
   - Extensions (up to 8 additional sessions) can be approved if needed
   - This includes youth insured through Medicaid
2. Provide ***navigation assistance*** for youth who are not looking for financial assistance and need help connecting to a provider

CONNECTING YOUTH TO A SWF PROVIDER

- Referrals are submitted ***online*** (by a youth serving professional or parent/guardian/caregiver)
- Youth is contacted by SWF within ***48 hours*** with a list of potential SWF providers, or the name of the provider designated by the youth serving professional/guardians
- Youth and their trusted adult or guardian call the SWF provider to get ***scheduled within 7 days***
- ***Youth and Provider determine*** how/when to utilize SWF services (the 12 sessions remain active until all have been used or up until their 20th birthday)

AS A PROVIDER WITH SWF

- You are either a licensed or candidate provider
- You determine the treatment plan; SWF ***does not*** need copies of notes, plans, diagnosis, etc.
- You schedule SWF Referrals ***within 7 days*** from the day of outreach
- You administer the ***SIQ at the 1st, 5th, and 12th session*** (SWF provides these - you do not score them)
- You bill SWF by email using ***our Claim Form*** to receive payment every week
- ****If caseload is full, let SWF know so Youth can be connected to another SWF Provider***

BENEFITS FOR SWF PROVIDERS

- Give back to the community
- Get paid $90/session; $45/2 NS/CA; $10/SIQ
- Get connected to registered events, CEU's, and consultation calls throughout the year

CONTACT SWF STAFF

Please contact us with any questions!

Make a Referral or Share with Guardians!

Second Wind Fund, Inc.
CLAIM FORM

I hereby submit the following claim for payment to Second Wind Fund, Inc.
I understand that all claims must be submitted **within 60 days of service.**

SWF Client Referral Number: _______________

Date of Service	Session #	**Cancellation/No Show** Two reimbursed at $45 each. Does not count toward 12 sessions total	**Address or school name of off-site visit only. Must travel a minimum of 2 miles for $20 reimbursement per trip.**

Suicidal Ideation Questionnaire (SIQ) Surveys Returned
Reimbursement is $20 after 2 SIQ's are submitted and total of $30 for all 3.

		Surveys submitted with this claim	*Reason not administered
SIQ # 1	Administered session #1		
SIQ # 2	Administered session #5		
SIQ #3	Administered last session		

*If not administered please explain why: child refused, language barrier, age, inappropriate timing clinically, will submit all at end, provider lacked forms, etc.

_________________________________ _________________

Signature of Therapist **Date**

Therapist Name and Address: If check is written to your business, please also include your name.

____

____

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____

New Address? Please submit a new W-9 Form

Phone: ______________________________

Payment via (please select one):

Check

bill.com (email SWF for activation code)

Office Use Only:

Ther: ________________

Trav: _________________ County:. _____________________________

SIQ: _________________ Appr. _________________________________

Total: ________________

Please send to: **Second Wind Fund, Inc**
Email: program@thesecondwindfund.org
Phone: 720-962-0706
Fax: 720-962-0821

Second Wind Fund, Inc.
CLAIM FORM

I hereby submit the following claim for payment to Second Wind Fund, Inc.
I understand that all claims must be submitted **within 60 days of service.**

SWF Client Referral Number: SWF 10000 — The referral number must be included. Please don't use the name of youth.

Date of Service	Session #	Cancellation/No Show Two reimbursed at $35 each. Does not count toward 12 sessions total	Address or school name of **off-site visit only**. Must travel a minimum of 2 miles for $20 reimbursement per trip.
1/1/2021	1 Teletherapy	If session was done via teletherapy please include.	
1/7/2021	2		
1/21/2021		1st No Show — Please include whether it was the 1st or 2nd now show.late cancelation.	
2/8/2021	3	Always include the session number.	
2/14/2021	4		Sunrise Elementary 123 Street Denver, CO 80123 — Include the address only if you traveled to see the youth.

Suicidal Ideation Questionnaire (SIQ) Surveys Returned
Reimbursement is $20 after 2 SIQ's are submitted and total of $30 for all 3.

If you have SIQs to submit please complete this section.

If you have completed SIQs but are not submitting yet, please don't complete this section until you submit.

		Surveys submitted with this claim	*Reason not administered
SIQ # 1	Administered session #1	1/1/2021	
SIQ # 2	Administered session #5		
SIQ #3	Administered last session		

*If not administered please explain why: child refused, language barrier, age, inappropriate timing clinically, will submit all at end, provider lacked forms, etc.

Signature of Therapist ____________________ **Date** ____________________

The treating therapist must sign the claim form. We can't process without a signature.

Therapist Name and Address: If check is written to your business, please also include your name.

Treating Therapist
Business Name
456 Counseling Court
Denver, CO 80203

Remember that this address must match your W9!

New Address? Please submit a new W-9 Form

Phone: ______________________________

Check
bill.com (email SWF for activation code)

Office Use Only:

Ther: ______________
Trav: ______________ County:. ______________
SIQ: ______________ Appr. ______________
Total: ______________

Please send to: Second Wind Fund, Inc
Email: program@thesecondwindfund.org
Phone: 720-962-0706
Fax: 720-962-0821

AUTHORIZATION FOR RELEASE OF INFORMATION AND WAIVER OF LIABILITY FOR SECOND WIND FUND, INC.

I, ____, hereby authorize
Name of Client (Student)

____
Name of Qualified Referral Source (i.e.: school counselor, social worker, psychologist)
and the professional therapist referred from Second Wind Fund, Inc., to release information to Second Wind Fund (SWF) for administrative purposes and evaluation of this program. I understand that the purpose of this authorization is to disclose information that is relevant to my mental health treatment. I further understand that any treatment records concerning my mental health treatment are confidential under Colorado law, and that statutory privilege prohibits confidential treatment information from being disclosed without my consent. This release of information expires in one year following completion or termination of treatment. This authorization may be revoked at any time in writing to Second Wind Fund, Inc., the qualified referral source (*i.e.: school district*) and the therapist.

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Client (Student) Signature / Date

__________________________________ __________________________________
Parent Signature / Date **2nd Parent Signature, if required / Date**
(Or Legal Guardian with decision-making authority)

WAIVER OF LIABILITY

I, ________________________**,** waive and release any claim that I may have or that my child,

_________________________, may have against Second Wind, Inc., its officers and directors, employees, agents, and members, the school that the student attends, the school district and all of their employees, for any negligence, claim, injury or damages whatsoever. This Waiver and Release is being made in exchange for the services which Second Wind Fund will be paying for. **I understand that Second Wind Fund is not providing services but funding them; and that no employee, Officer or Director of Second Wind Fund will be providing services or treatment. I further understand that the treatment professionals to whom referrals may be made by Second Wind Fund are independent professionals who are neither employees nor agents of Second Wind Fund.**

I am hereby informed that I should safeguard all obvious means for suicide, such as firearms, ammunition, and both prescription and over-the-counter medications.
This Waiver is made freely and voluntarily, and I acknowledge that I have read this Waiver and understand it.

____
Client (Youth) Signature / Date

__________________________________ __________________________________
Parent Signature / Date **2nd Parent Signature, if required / Date**
(Or Legal Guardian with decision-making authority)
After this SWF Release/Waiver form is signed, please keep one signed copy in your school confidential file for the student and give two copies to the family – one must be given to the SWF therapist at the first session.

Updated 11/2020