



## **SCHOOL BASED HEALTH CENTERS STAFF ENROLLMENT FORM & INFORMATION Caroline and Talbot Counties**

### **Dear Staff:**

As a staff member in the Caroline & Talbot County Public School systems, you have access to the Choptank Community Health SCHOOL BASED HEALTH CENTERS.

The mission of the Centers is to **improve the health of students and faculty, increase access to primary health care and decrease time lost from school by providing care** within the school setting. We are a **convenient source of quality health care** that works in collaboration with your doctor and the school nurse.

Choptank Community Health recognizes the connection between health and positive academic outcomes. CCHS is pleased to partner with the Caroline & Talbot County Public Schools and the Caroline & Talbot County Health Departments to ensure that students & staff are healthy.

### **SERVICES AVAILABLE IN THE SCHOOL BASED HEALTH CENTERS**

congestion	cough	earaches
headaches	follow-up health care	referrals to specialists
health risk assessments	health education	pain or injuries
skin itch/rash	prescriptions	shortness of breath
sore throat evaluation	physicals	nausea /vomiting evaluation
strep throat tests	sports physicals	blood pressure screenings

You can receive medical treatment right at school! There is no need to take time off from work to go to the doctor or travel to/from school, home and an off-site medical facility. These licensed medical providers can:

assess patients	diagnose illnesses
write prescriptions	provide medications in school
perform lab tests	discuss healthy choices

# SCHOOL BASED HEALTH CENTERS

## STAFF ENROLLMENT FORM & INFORMATION

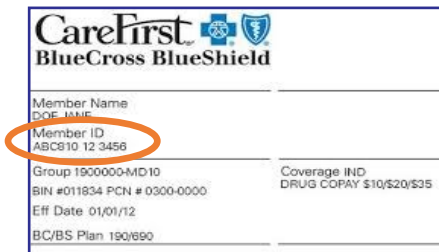
### ADDITIONAL INFORMATION

The mission of the Centers is to **improve the health of students and faculty, increase access to primary health care** and **decrease time lost from school by providing care** within the school setting. We are a **convenient source of quality health care** that works in collaboration with your doctor and the school nurse.

**SERVICES:** In addition to the services mentioned above, SBHC providers can assist in managing chronic illnesses, provide health education, referrals to specialists and sports physicals for school endorsed sports. Whenever you are seen by the Health Center staff, a visit summary note is available that details the visit.

**COST:** Federal and state regulations require all providers, including Choptank Community Health (CCHS), to bill all patients for School Based Health Center program services. The Medicaid programs cover School Based Health Center charges. If you have health insurance, we will bill the insurance company for health services and follow the billing requirements associated with your plan. **Depending on your insurance plan, payment will be due at the time of visit for copays, unmet deductibles and any non-covered services.** If CCHS is not a participating provider with your insurance plan, you will be billed directly for services. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon their income. All patients are eligible to apply for the sliding fee program even if they have insurance. Finally, the cost associated with lab services will be billed to your insurance. Bills for these tests will come directly from the lab company.

**ENTERING INSURANCE INFORMATION ON THE ENROLLMENT:** Please provide as much information as possible regarding your insurance. Examples include:



**ENROLLMENT:** All Public School staff can enroll in the program. Please complete the attached enrollment form. Return it to the school nurse or the Health Center. Once you are enrolled in the Health Center, you will not need to re-enroll each year.

**If you have any questions about the program, please contact CCHS at (410) 479-4306, ext. 1038**

**STAFF ENROLLMENT FORM**

OFFICE USE ONLY:

Entered  
 Posted  
 Scanned

**PATIENT INFORMATION**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_  
 DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ Male / Female  
 SOCIAL SECURITY #: \_\_\_\_\_  
 RACE: \_\_\_\_\_ HISPANIC/LATINO?: YES / NO  
 PREFERRED LANGUAGE: \_\_\_\_\_  
 DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 PHARMACY: \_\_\_\_\_ PHONE: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

CONTACT NAME: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_  
 PREFERRED LANGUAGE: \_\_\_\_\_  
 #1 PHONE: \_\_\_\_\_  
 #2 PHONE: \_\_\_\_\_  
 SECOND CONTACT: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_  
 PREFERRED LANGUAGE: \_\_\_\_\_  
 #1 PHONE: \_\_\_\_\_  
 #2 PHONE: \_\_\_\_\_

**HEALTH INSURANCE**

INSURANCE NAME: \_\_\_\_\_ POLICY/MEMBER ID#: \_\_\_\_\_  
 SUBSCRIBER NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
 SUBSCRIBER DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ CLAIMS ADDRESS: \_\_\_\_\_  
 SUBSCRIBER EMPLOYER: \_\_\_\_\_

**HEALTH/DENTAL HISTORY**

LIST ALL MEDICATIONS YOU TAKE ON A DAILY BASIS:

MEDICATION: \_\_\_\_\_ DOSE: \_\_\_\_\_ mg DIRECTIONS: \_\_\_\_\_  
 MEDICATION: \_\_\_\_\_ DOSE: \_\_\_\_\_ mg DIRECTIONS: \_\_\_\_\_

(PLEASE ATTACH ADDITIONAL MEDICATIONS)

YES / NO DO YOU HAVE MEDICATION / FOOD / ENVIRONMENTAL ALLERGIES?  
 IF YES, PLEASE LIST: \_\_\_\_\_

YES / NO HAVE YOU HAD ANY RECENT HOSPITALIZATIONS OR SURGERIES?  
 IF YES, PLEASE LIST: \_\_\_\_\_

YES / NO DOES ANYONE SMOKE IN THE HOME?

YES / NO HAVE YOU COMPLAINED OF DENTAL PAIN IN THE PAST SIX MONTHS?

YES / NO HAVE YOU SEEN A DENTIST WITHIN THE PAST SIX MONTHS? Last Visit?: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

STAFF Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**PATIENT HISTORY**

HAVE YOU EVER HAD THE FOLLOWING?  
(circle "yes" or "no")

- YES NO ADD/ADHD
  - YES NO ANEMIA
  - YES NO ASTHMA/BREATHING
  - YES NO BLOOD DISORDER
  - YES NO CANCER
  - YES NO DEVELOP. DISABILITY
  - YES NO DIABETES
  - YES NO HEADACHES/MIGRAINE
  - YES NO HEARING/VISION
  - YES NO HEART PROBLEMS
  - YES NO HIGH BLOOD PRESSURE
  - YES NO HIV/AIDS
  - YES NO KIDNEY/BLADDER
  - YES NO LEAD POISONING
  - YES NO LIVER PROBLEMS
  - YES NO MENTAL ILLNESS
  - YES NO OBESITY
  - YES NO SEIZURES/EPILEPSY
  - YES NO SKIN PROBLEMS
  - YES NO STOMACH PROBLEMS
  - YES NO STROKE
  - YES NO THYROID PROBLEMS
  - YES NO TOOTH DECAY
  - YES NO TUBERCULOSIS
- OTHER: \_\_\_\_\_

**FAMILY HISTORY**

HAS AN IMMEDIATE FAMILY MEMBER (parent, sibling, child, grandparent)  
EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

- YES NO ADD/ADHD Who?: \_\_\_\_\_
  - YES NO ANEMIA Who?: \_\_\_\_\_
  - YES NO ASTHMA/BREATHING Who?: \_\_\_\_\_
  - YES NO BLOOD DISORDER Who?: \_\_\_\_\_
  - YES NO CANCER Who?: \_\_\_\_\_
  - YES NO DEVELOP. DISABILITY Who?: \_\_\_\_\_
  - YES NO DIABETES Who?: \_\_\_\_\_
  - YES NO HEADACHES/MIGRAINE Who?: \_\_\_\_\_
  - YES NO HEARING/VISION Who?: \_\_\_\_\_
  - YES NO HEART PROBLEMS Who?: \_\_\_\_\_
  - YES NO HIGH BLOOD PRESSURE Who?: \_\_\_\_\_
  - YES NO HIV/AIDS Who?: \_\_\_\_\_
  - YES NO KIDNEY/BLADDER Who?: \_\_\_\_\_
  - YES NO LEAD POISONING Who?: \_\_\_\_\_
  - YES NO LIVER PROBLEMS Who?: \_\_\_\_\_
  - YES NO MENTAL ILLNESS Who?: \_\_\_\_\_
  - YES NO OBESITY Who?: \_\_\_\_\_
  - YES NO SEIZURES/EPILEPSY Who?: \_\_\_\_\_
  - YES NO SKIN PROBLEMS Who?: \_\_\_\_\_
  - YES NO STOMACH PROBLEMS Who?: \_\_\_\_\_
  - YES NO STROKE Who?: \_\_\_\_\_
  - YES NO THYROID PROBLEMS Who?: \_\_\_\_\_
  - YES NO TOOTH DECAY Who?: \_\_\_\_\_
  - YES NO TUBERCULOSIS Who?: \_\_\_\_\_
- OTHER: \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that my signature gives consent for the CCHS School Based Health Center Providers to treat me and to communicate with my primary health care provider. I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. I understand that my health information will be used for treatment, payment and health care operations. CCHS may also mail healthcare information to my home. I recognize that school directories may be used to obtain information left blank on the enrollment form. For the purposes of care coordination and case management School Clinical Staff will have access to the SBHC health records and School Clinical Staff shall share health information with the SBHC staff, and School Clinical Staff are required to treat the information in the SBHC health record as confidential and comply with the HIPAA Privacy Rule. I understand that services provided to me will be billed to my insurance carrier. I understand that I am responsible for any portion of my visits not covered by my insurance carrier and, I required to pay to CCHS any copays and/or deductibles at the time that services rendered. I understand that my signature indicates that I have had the opportunity to receive and review the Choptank Community Health's Notice of Privacy Practices. If I do not have insurance, I will be billed for the full cost of services or at my sliding fee discount, if applicable.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE RETURN COMPLETED ENROLLMENT TO YOUR SCHOOL NURSE OR SBHC. THANK YOU!**