

SCHOOL BASED MEDICAL / DENTAL CENTERS ENROLLMENT FORM & INFORMATION

Talbot County Schools

Dear Parent/Guardian:

As a student in the Talbot County Public School systems, your child has access to the Choptank Community Health SCHOOL BASED HEALTH & DENTAL 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 child's doctor and the school nurse.

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

Your child can receive medical treatment right at school! Common complaints and reasons for a visit to the School Based Health Center include:

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

SERVICES AVAILABLE IN THE SCHOOL BASED HEALTH CENTERS

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

SERVICES AVAILABLE IN THE SCHOOL BASED DENTAL PROGRAMS

As a student in the **Talbot** County Public School system, your child has access to the **School Based Dental Program**. The program is a partnership between the Public Schools, County Health Departments, and Choptank Community Health System (CCHS).

Services may include:

dental screening	polishing/cleaning	fluoride (may be applied twice)
dental sealants	oral health education	dental emergency referrals

The School Based Dental program does not take the place of your primary dentist. A dental hygienist will screen your child to determine which services will be provided or if a referral is necessary. The hygienist provides care in the school setting that promotes healthy teeth and gums. Your child should go to your dental office for a complete exam with x-rays as often as recommended by your dentist.

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ADDITIONAL INFORMATION

The mission of the School Based Health 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 child's doctor and the school nurse.

SERVICES: In addition to the services mentioned above, SBHC providers can assist in managing chronic illnesses, conduct *Healthy Child Chats*, provide health education, referrals to specialists and sports physicals for school endorsed sports. Whenever your child is seen by the Health Center staff, a note is sent home that details the visit. Additionally, a report on the visit is shared with your child's primary health care provider.

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 your child has 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, you may receive a bill from CCHS 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. 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 child's insurance. Examples include:

CareFirst BlueCross BlueShield	
Member Name DOE, JANE	
Member ID ABC810 12 3456	
Group 1900000-MD10	Coverage IND
BIN #011834 PCN # 0300-0000	DRUG COPAY \$10/\$20/\$35
Eff Date 01/01/12	
BC/BS Plan 190/690	

PRIORITY partners		Participant in Maryland HealthChoice
Name: SAMPLE CARD		Customer Service: 1-800-654-9728
ID #: 000963717*01		TTY LINE: 410-424-4643
Recip # 123456789		1-888-232-0488
Doctor: ANNAPOLIS REGIONAL MEDICAL CEN		Recipient#: 00011122233
Doctor Phone: (410)266-1000		Eff. Date: 09/01/2010
Prescription Drug Co-Pays		
Generic: \$1.00 Brand: \$3.00		
Prescription Drug co-pays apply to members age 21 and older.		
Bin #610084	W7579999	CAREMARK

SLIDING FEE PROGRAM: The enrollment form has an area to complete to apply for our Sliding Fee Program, if you are interested. Patients on the sliding fee program can receive discounts that will be billed based upon their income. All patients and their families are eligible to apply for the sliding fee program, even if they have insurance.

ENROLLMENT: All Public School students can enroll in the program. Please complete the attached enrollment form. Return it to the school nurse or the Health Center. Once your child is enrolled in the Health Center, they 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

___ I want to enroll my child in the School Based Health Center and the School Based Dental Program.

___ I want to enroll/update my child in the School Based Health Center Only.

___ I want to enroll/update my child in the School Based Dental Program Only.

My child is a student at: _____ **School Grade:** _____ **Homeroom Teacher:** _____

STUDENT INFORMATION

NAME: _____

ADDRESS: _____

DOB: _____ Male / Female

SOCIAL SECURITY #: _____

RACE: _____ HISPANIC/LATINO?: YES / NO

PREFERRED LANGUAGE: _____

DOCTOR: _____ PHONE: _____

DENTIST: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

PARENT/GUARDIAN INFORMATION

NAME: _____

RELATIONSHIP: _____

PREFERRED LANGUAGE: _____

#1 PHONE: _____

#2 PHONE: _____

EMAIL: _____

OK to TEXT?: YES / NO

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE: _____ PHONE: _____

HEALTH INSURANCE

INSURANCE NAME: _____

POLICY/MEMBER ID#: _____

GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: ____/____/____

CLAIMS ADDRESS: _____

DENTAL INSURANCE

INSURANCE NAME: _____

POLICY/MEMBER ID#: _____

GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: ____/____/____

CLAIMS ADDRESS: _____

No Insurance? Would you like to apply for the Sliding Fee?: YES / NO Household # of People?: ____ Income: \$ _____ /yr.

HEALTH/DENTAL HISTORY

DAILY MEDICATIONS: _____

ALLERGIES to MEDICATION / FOOD / ENVIRONMENTAL : _____

YES / NO HAS YOUR CHILD HAD ANY RECENT HOSPITALIZATIONS OR PREVIOUS SURGERIES?
IF YES, PLEASE LIST: _____

YES / NO DOES ANYONE IN THE HOME SMOKE? YES / NO DRUG/ALCOHOL ADDICTION?

YES / NO HAS YOUR CHILD COMPLAINED OF DENTAL PAIN IN THE PAST SIX MONTHS?

YES / NO HAS YOUR CHILD SEEN A DENTIST WITHIN THE PAST SIX MONTHS? Last Visit?: ____/____/____

STUDENT Name: _____

DOB: _____

STUDENT HISTORY

HAS CHILD EVER HAD ANY OF 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, 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/Dental Center Providers to treat my child and to communicate with my child's primary health care provider. I give CCHS permission to call my home, leave a message regarding healthcare information. CCHS may also mail healthcare information to my home.
- ◊ I understand that my child's health information will be used for treatment, payment and health care operations.
- ◊ I recognize that school directories will be used to obtain information left blank on the enrollment form.
- ◊ My child's immunization record may be shared between the School Nurse and the School Based Health/Dental Centers. For the purposes of care coordination and case management, School Clinical Staff will have access to the SBHC/SBDP health records and School Clinical Staff shall share health information with the SBHC/SBDP staff. School Clinical Staff are required to treat the information in the SBHC/SBDP health record as confidential and comply with the HIPAA Privacy Rule and the FERPA Act.
- ◊ I understand the student may request that visits remain confidential. Maryland Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, or contraception. Students age 16 and over may receive mental health services without parental consent. Under no circumstances, do SBHC/SBDP records become part of the student's school health record.
- ◊ I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles.
- ◊ 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, visit costs will be billed for the full cost of services or at a reduced rate with a sliding fee discount, if applicable. I will be offered a Sliding Fee Application whether or not I have health/dental insurance.

Parent/Guardian Signature: _____

Date: _____

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

Documented and reviewed by: _____