CHOPTANK community health

see how healthy you can be!

SCHOOL BASED HEALTH CENTERS
STAFF ENROLLMENT FORM & INFORMATION

Dear School Staff:

As a staff member in **Caroline, Talbot, Kent and Queen Anne's County Public Schools**, 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 public school systems and local 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
- nutrition services
- health education
- pain or injuries
- skin itch/rash
- prescriptions
- shortness of breath
- sore throat evaluation
- physicals
- nausea /vomiting evaluation
- strep throat tests
- behavioral health
- health 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
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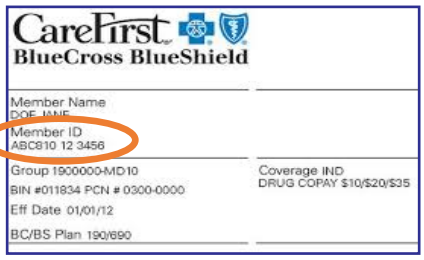
ADDITIONAL INFORMATION

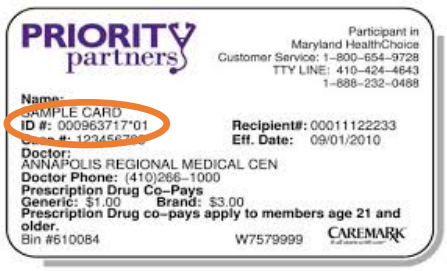
The mission of the Centers is to **improve the health of students and faculty**, **increase access to primary health care** and **decrease time lost from school by providing care** within the school setting. We are a **convenient source** of **quality health care** that works in collaboration with your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

For after-hours medical or dental emergencies, please call 443-329-9920 to reach the Choptank on call provider.

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School Based Health Center

STAFF ENROLLMENT FORM

OFFICE USE ONLY:
___ Entered
___ Posted
___ Scanned

PATIENT INFORMATION

NAME: _____
ADDRESS: _____
PHONE: _____
EMAIL: _____
DOB: _____ M / F School:_____
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: _____
SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____/_____/_____
SUBSCRIBER EMPLOYER: _____
POLICY/MEMBER ID#: _____
GROUP #: _____
CLAIMS ADDRESS: _____
_____

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 / ENRIVONMENTAL 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?: _____/_____/_____

Complete & Sign Page 2

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!