LEWISTON-AUBURN
SCHOOL-BASED HEALTH CENTERS
Community Clinical Services - FQHC
Affiliated with St. Mary's Health System

***Parents/Guardian*-For initial enrollment, please complete <u>all pages</u> of this form to allow your child to use the School-Based Health Center. This is an optional service, in addition to the school nurse. We partner with your students' primary care doctor to coordinate care, we do NOT replace them. There is <u>no</u> enrollment fee to participate in this service.**

Demographics:

Name:_____ Date of Birth:_____ Sex (circle one): M F

Address:_____ Primary phone:_____

School (circle one): LMS LHS LRTC AMS ELHS RETC FRANKLIN Grade:_____

Race: (circle one): -American Indian/Alaskan Native -Asian -Black -White -Hawaiian/Pacific Islander -Two or More Races -Other

Ethnicity (circle one): -Hispanic or Latino/a -Non-Hispanic

Where does your child receive medical care?_____Date of Last Physical ___/___/___
Doctor/ Provider's Name:_____

Emergency Contact Information:

Parent/ Guardian:_____Phone: Home:_____Work:_____Cell:_____
Name/ Relationship:_____Phone: Home:_____Work:_____Cell:_____
Email address:_____

Medical/ Health Information:

The Health Centers *work together* with your child's PCP or medical provider(s). So that we can work as a team to provide the best services, please list your child's diagnosed medical conditions (eg: Asthma, Diabetes, etc.)

_____ _____
_____ _____

Does your child take medication(s) for any of these conditions? If so, please list name(s) & dose(s):

_____ _____
_____ _____

ALLERGIES: _____ Type of Reaction:_____

Hospitalizations, significant past illnesses, injuries or surgeries: _____
_____

Depression or other mental health issues (anxiety, ADHD, etc.) _____
Would you like your child referred to a SBHC counselor for Mental Health or Substance Abuse Services (circle one)?
Yes No (Please note: If child already has a counselor in the community, we cannot also provide care)

FOR LEWISTON SCHOOLS ONLY. Please do NOT complete this portion, if your student attends Auburn Schools.

Permission for the Health Center to administer the following over- the-counter medications, as needed, at no charge:

<u>Please circle Yes or No:</u> Acetaminophen **(Tylenol)** Yes No Ibuprofen **(Advil)** Yes No **Cough drops** Yes No
Diphenhydramine (**Benadryl**) Yes No **Throat Lozenges** Yes No Antacids **(Tums)** Yes No

➔**Parent/Guardian Signature:**_____Date: _____

*******IMPORTANT**** Please complete page two of this form ****IMPORTANT*******

Health Insurance Information:

Student's Health Insurance Information MUST be completed: **Student does NOT have insurance _____**

Insurance Company: _____ Policy # _____Group # _____
Insurance Address (on back of card): _____ Insurance Phone # _____
Person who holds coverage (Subscribers Name): _____ DOB: ___/____/_____ SS #:_____
Secondary Insurance Company: _____ Policy # _____Group # _____
Insurance Address (on back of card): _____ Insurance Phone # _____
Person who holds coverage (Subscribers Name):_____ DOB:___/____/_____ SS #: _____

Consent for Treatment and Payment & Health Information Portability and Accountability Act :

* I authorize release of medical and related information, reportable communicable disease, and mental health records obtained in the course of diagnosis and treatment to my health insurance company or other third party payer for the purpose of obtaining payment for service rendered. Authorization may be withdrawn at any time by written notification.
* I give permission for my child to receive medical/mental healthcare and education at the School-Based Health Center.
* I understand that as an enrolled patient my child will be given a Health Risk Assessment (HRA) which will be reviewed by the Nurse Practitioner (NP) during an office visit. Services provided by the NP will be billed to the insurance company listed above and there will be no charge to me.
* I understand that over the counter medications will be administered to my child **IF** I have given permission for this service **AND** only if my student is in the Lewiston School System.
* I understand that the SBHC staff will share pertinent information with my student's PCP to provide collaborative care (i.e. if medication is prescribed)
* I agree that my child may be photographed for marketing purposes.
* I hereby authorize the Lewiston and./or Auburn School Based Health Center Team involved with my student's care to disclose to and/or obtain health and education information/records from Lewiston and/ or Auburn School Staff involved in educational services for my student for the following purposes:

  - ✓ Educational evaluation and program planning.
  - ✓ Health assessment and planning for health care services and treatment in school.
  - ✓ Medical evaluation and treatment
  - ✓ Other: _____

The education information to be disclosed consists of: verbal conversations regarding educational planning, special education services (if applicable), and school performance/behavioral issues (if applicable)
The health information to be disclosed consists of: verbal conversations regarding care to be provided as it relates to the school setting.

Authorization: This authorization is valid for the duration of time that the student is enrolled with the Lewiston or Auburn School System or until they transfer to another school (i.e. from middle school to high school). I acknowledge that when my student transfers from middle school to high school, I must re-enroll them in the health center if I would like for them to continue receiving services at the School Based Health Center. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPPA Act, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I have read this form completely and agree to enroll my student in the health center at this time.

➔Parent/Guardian Signature: _____Date: _____
Please Print Name: _____Relationship to Child: _____

Patient/Student Signature*: _____Date: _____

* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Maine, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, sexual assault evaluation and reproductive health care service

COMMUNITY CLINICAL SERVICES

A Federally Qualified Health Center
Affiliated with St. Mary's Health System

INCOME VERIFICATION FORM

Community Clinical Services is a Federally Qualified Health Center (FQHC). This allows us to provide needed healthcare services to individuals regardless of their ability to pay. Because we are an FQHC, we are required to gather information on household size and income for the patients we serve. By providing CCS with this information you may also qualify to receive a discount on your medical billing and may be eligible for free and/or low cost medications. If we determine that you are eligible for a program listed above, we will contact you for more information or send you the appropriate application to apply.

PLEASE NOTE: YOUR PERSONAL INFORMATION IS CONFIDENTIAL IT IS NOT DISCLOSED TO ANYONE, AND IS ONLY USED TO DEVELOP STATISTICS.

Family Size	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 or More Persons
Please Check The Appropriate Box								

Housing Status: ☐ Homeless ☐ Veteran ☐ Public Housing ☐ Other

Household Income: Please Check the Appropriate Box

	Less than $12,000		$48,001 to $52,000
	$12,001 to $16,000		$52,001 to $56,000
	$16,001 to $20,000		$56,001 to $60,000
	$20,001 to $24,000		$60,001 to $64,000
	$24,001 to $28,000		$64,001 to $68,000
	$28,001 to $32,000		$68,001 to $72,000
	$32,001 to $36,000		$72,001 to $76,000
	$36,001 to $40,000		$76,001 to $80,000
	$40,001 to $44,000		More than $80,001
	$44,001 to $48,000		