BLUE RIDGE
HEALTH

Dear Parent/Guardian,

As we begin another year, Blue Ridge Health would like to remind you that school-based health services are available for your child on-site, in your school. Some visits may be provided via telehealth for your convenience. We can treat illnesses, provide urgent care and help students manage already known medical conditions. We encourage you to sign your student up today so the service is available when you need it.

By offering medical care on-site or via telehealth by Physicians, Physician's Assistants and Nurse Practitioners, overseen by our Medical Director MaryShell Zaffino, we minimize potential disruptions to your child's school day and your workday. We work with you, the school nurses and your child's primary care physician to provide the best care possible. We can even call in prescriptions to your normal pharmacy if your child is in need of medication, and our provider will contact you later that day to discuss the visit! Our counselors, nurses and dietitians can, among other things:

- Support and care for acute problems like colds, the flu, ear infections and strep throat
- Behavioral Health issues such as ADHD
- Common conditions and illnesses like pink eye and urinary symptoms
- Work with children who face school, social and family challenges

The health center in your child's school provides a number of services free of charge. However, when medical decision-making and/or a prescription are necessary, we operate like any other doctor's office and bill health insurance for medical visits. For this reason, we ask that you provide the requested insurance information on the back of the permission form.

If you do not have health insurance, we are happy to help you and your family apply for coverage that best meets your needs. For those without insurance, we offer an affordable sliding fee scale.

These services are available to your child **with your signed permission on the attached "BRCHS School Health Center Student Registration and Permission Form".**

To register your child:

- ☐ Complete and sign the attached registration form
- ☐ Provide insurance information, if applicable
- ☐ Complete the Application for Discount services
- ☐ Return to the School Based Health Center or your child's teacher

Our office is open school days 7:45am – 3:30pm. Please call (828) 233-2280 or stop by with any further questions, to meet our staff or tour the health center. We'd love to meet you!

Blue Ridge Health - School Based Health Center Staff

BLUE RIDGE HEALTH

2020-2021 BRH SCHOOL HEALTH CENTER STUDENT REGISTRATION & PERMISSION FORM

STUDENT INFORMATION | **ATTENDING SCHOOL:**

Name (Last, First, Middle)	Birth Date / /	Gender ☐ Male ☐ Female	Grade/ Teacher
Ethnicity ☐ Hispanic ☐ Non-Hispanic	Race ☐ Native American ☐ White ☐ African American ☐ Asian		Primary Language Spoken If Not English
Does the child have a regular doctor or other medical provider? ☐ Yes ☐ No Name of Provider or Clinic:	Does the child have a regular dentist or dental clinic provider? ☐ Yes ☐ No Name of Dentist or Dental Clinic: If no, why does the child not have a dentist?		

PARENT / COURT ORDERED LEGAL GUARDIAN INFORMATION

Name Date of Birth	Relationship to Student	Does student live with you? ☐ Yes ☐ No
Street Address	City, State, Zip	
Daytime Phone # / Work phone # and ext.	Other Phone (cell phone) #	Email Address
In Case of Emergency Contact/Relationship to Student	Phone #	Other Phone (cell phone) #

STUDENT MEDICAL HISTORY

Medication allergies: Reaction:

Other allergies: Reaction:

Daily medications: Reason for taking: How long have they taken this medication? **Preferred Pharmacy:**

Chronic Medical Conditions: **(Check all that apply)**

☐ Diabetes ☐ Attention Deficit Disorder (ADD/ADHD ☐ Asthma ☐ Sickle Cell Disease ☐ Kidney Disease ☐ Depression
☐ Heart Problems ☐ Anemia ☐ Epilepsy ☐ Autism/Autism Spectrum Disorder ☐ Developmental Delay
☐ Other Issues: _____

Has your child ever had chicken pox? ☐ Yes ☐ No **If yes, when?** / /

Has there been any change in your child's health during the past year? ☐ Yes ☐ No **If yes, explain.**

Has this child had a recent complete physical exam? ☐ Yes ☐ No **If yes, when?** / /

If no, Would you like for your child to receive a complete physical in the School Health Center? ☐ Yes ☐ No **If yes, please sign the statement below:**

I give permission for my child to have a complete physical exam at the School Health Center – signature: _____

I would like to be present for my child's exam. ☐ Yes ☐ No We will contact you before and after the appointment.

Has this child been seen in the emergency room in the past year? ☐ Yes ☐ No **If yes, when and why?**

Has this child ever had to stay in the hospital or have surgery? ☐ Yes ☐ No **If yes, when and why?**

Last dental exam? / / Any dental concerns? ☐ Yes ☐ No **If yes, explain.**

Has your child ever had any serious sports-related injuries? ☐ Yes ☐ No **If yes, give the age it occurred and describe injury.**

If your child receives a Sports Physical in the School Health Center, do you consent to releasing a copy of your child's completed sports physical forms to the school for sports participation purposes? ☐ Yes ☐ No

Is there anything else you would like for the school health center to know about your child?

HOUSEHOLD INFORMATION

Please name the people living in your household and their ages: **Example: Father (40), Stepmother (40), Sisters (6&8), Uncle (50), etc.**

Does anyone in the household smoke? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Does anyone in this child's immediate family have any current health concerns? ***(Diabetes, High Blood Pressure, Asthma etc.)***

Family Member Age Health Concern

TURN OVER PLEASE – BACK OF FORM MUST BE COMPLETED

NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES

Available upon request and on our website www.brchs.com you will find a **Notice of Privacy Practices** that details the way we keep your child's medical record confidential, and what rights you have to access that medical record. You will also find a form listing Student and Parent Rights & Responsibilities. We are required by Federal Law to provide you with this information and we ask that you **read the Notice of Privacy Practices and Rights & Responsibilities for both you and your child.** Please call (828) 692-4289 and speak to our BRH Privacy Officer if you have any questions. Thank you for your cooperation in our effort to comply with this law.

INSURANCE INFORMATION* Please send a copy of your insurance cards with this form or send the original (we will make a copy and return the card to you)

Is the student covered by Medicaid or NC Health Choice? ☐ Yes ☐ No ☐ Pending Medicaid or NC Health Choice ID#:	Would you like information about Medicaid or NC Health Choice? ☐ Yes ☐ No Do you have another child in the home on Medicaid/NC Health Choice? ☐ Yes ☐ No What was this child's birthplace? State: Country:

Is the student covered by insurance? ☐ Yes ☐ No **(If NO, please fill out the sliding fee information below to qualify for discounted charges)**			Would you like information about how you could get insurance through the Health Insurance Marketplace? ☐ Yes ☐ No
Private Insurance	Name of Policyholder	Date of Birth	Relationship to student
Insurance Company Address **(to mail medical claims – check on the back of your insurance card)**			Insurance Phone #
ID Number (Policy #)	Group Number		Social Security # **(for insurance purposes only)**
Date Coverage Began		What is your deductible or co-pay?	
Policyholder's Employer		Employer Address	

Are you employed in Agriculture? ☐ Yes ☐ No

If yes, what type of position do you hold? ☐ Grower ☐ Migrant Farmworker (travel to seek work) ☐ Year-round Farmworker
☐ Seasonal Farmworker (live here; agriculture work during harvest season)

APPLYING FOR THE BRH DISCOUNT SERVICES PROGRAM: ☐ **Yes – I want more information on the BRH Discount Services Program**
If your child is uninsured at any time during the school year or you have a high insurance deductible plan, we would like to help by determining if you would qualify for discounted charges or our "sliding fee" which uses similar eligibility to the federal free and reduced lunch program. If you'd like to apply for this program, additional information must be completed to determine eligibility. Eligibility will be good for the entire school year.

1. I give consent for my child to receive any of the available services at a BRH School Health Center. BRH School Health Centers provide medical, dental, behavioral health, nutrition and social work services to enrolled students who have completed registration, including written consent and signature of the parent or legal guardian. Staff of the BRH School Health Center will inform parents of significant findings and treatment recommendations for minor children, for conditions other than those exempted by state law. For your convenience and at your request, some services may be provided by telehealth.
2. I authorize the release to my child's primary care provider, School Nurse and Student Support Services any medical information pertinent to my child's general health and care while they are at school. I authorize the release of information from my child's primary care provider, School Nurse, and Student Support Services to the BRH School Health Center for coordination of care.
3. I authorize the release of any medical information, including information on communicable diseases, dental, behavioral health and nutrition information necessary to process an insurance claim for payment of benefits to the BRH School Health Centers.
4. I authorize payment of insurance benefits for services rendered at the BRH School Health Centers, though Blue Ridge Community Health Services Inc.
5. I understand that Blue Ridge Community Health Services (BRH) operates the School Health Centers and I must contact BRH to make special payment arrangements if I am unable to pay the bill in full.
6. I understand that all my child's records will be strictly confidential, and maintained in compliance with state and federal laws, including HIPPA and FERPA and any paper records will be maintained onsite at the BRH SHC facility. Information is not shared with teachers, principals, or other students.
7. I confirm that all information given is complete and accurate.

Please sign the following declaration: **By signing this form, I authorize my child to receive all services available from the School Health Center. I understand that this consent is voluntary and is valid for the entire time that my child is enrolled in school. I understand that I may also revoke my consent, in writing, at any time. I understand that it is my responsibility to provide up-to-date information on the insurance coverage I carry on my child, including Medicaid and NC Health Choice. I also understand that I am financially responsible for all charges and any co-pays or deductible amount not covered by my insurance. I further understand I am responsible for understanding my own insurance plan and whether services are covered or require pre-authorization. If services require pre-authorization, I understand this is my responsibility.**

Parent/Guardian Signature:_____ **Date:**_____/_____/_____

NO STUDENT WILL BE DENIED HEALTH SERVICES BASED ON THEIR PARENT OR LEGAL GUARDIAN'S INABILITY TO PAY

TURN OVER PLEASE – BACK OF FORM MUST BE COMPLETED

BLUE RIDGE
HEALTH

APPLICATION FOR DISCOUNT SERVICES

Patient Name:_____ **Phone:** _____

Please mark each statement that applies to you or a family member who is also on this application. This information will not be used to withhold or deny services to you or your family.

I. SLIDING FEE SCHEDULE

As a Federally Qualified Health Center, BRCHS offers a Sliding Fee discount program for those who qualify. **You may receive the discounted rate even if you have private insurance**, Marketplace insurance, or Medicare, if the discounted rate is lower than your normal out-of-pocket cost. If you are not eligible for the sliding fee scale, choose not to apply, or do not provide household and income information, you will be expected to pay the full charge for care. (See the **Acknowledgement if NOT applying for Sliding Fee Schedule** at the end of this document).

I would like to see if I qualify for discount services under BRCHS's Sliding Fee Schedule. Yes _____ **No** _____

II. ELIGIBILITY VERIFICATION:

Household information: Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to You	Type of Health Insurance?	Farmworker in past 2 years?	Veteran?
		Self			

Gross Income: Please list your household's **gross income** (the $ amount received before taxes are taken out). Household income includes *everyone* in the home. Proof of income includes: most recent tax return, check stubs, Social Security statement, letter from employer stating wages earned, or proof of unemployment.

Income type (i.e. Wages, Soc. Sec., Child Support, other income)	**Name of Family Member**	**Gross Amt.** (pre-tax)	**Frequency** (weekly(x52), bi-weekly (x26), bi-monthly (X24) or monthly (x12).)
		$	
		$	
		$	

If there is no income to report, or if you are unable to document your income, you must complete the **Patient Certification Statement** section below.

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature_____ **Date**_____

[OVER PLEASE]

Acknowledgement if NOT applying for Sliding Fee Schedule

I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and **I do not wish to apply for the BRCHS discount services sliding fee program** at this time, or have been told that I do not qualify for a sliding fee discount. I understand that if I do not have insurance at the time of service, I will be responsible for any and all balances due after the provider's charges for my visit are entered. I will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges is not applicable and I will not be allowed to receive a retroactive discount for these charges in the event that a future sliding scale application is completed.

Patient Signature_____ **Date:** _____

Consent for Application for Discount Services

I certify that the **information provided above is accurate and complete** to the best of my knowledge. In the event of a change in income or insurance coverage, I will notify BRCHS at my next appointment. I understand that **I will be financially responsible for all or a portion of my care** and that I will be **asked to submit payment at the time of service**. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled. I understand that BRCHS uses a system called Oasis Insight or an Electronic Health Record to help determine eligibility for sliding fee and other services and I consent to have the above information stored in those systems.

Patient Signature_____ **Date**_____

III. POTENTIAL BARRIERS TO CARE

This list is used to help us identify other areas in your life that may need some additional community resources. It will help us develop a plan of action, including referrals to appropriate departments and outside organizations. If you would like more information, or have any question on the items below, check the box so that a Patient Navigator can assist you.

Health Insurance / Health Care Access

- ☐ I need health insurance (Medicaid, ACA Insurance, Family Planning, or other programs)
- ☐ I need to sign up for Medicare or need Medicare Counseling (SHIIP)
- ☐ I need help completing a Charity Care applications for my local hospital system
- ☐ I need help paying for my medications (This does not include usage of a discounted medication or medication assistance program.)
- ☐ I need to apply for a tax exemption because I'm uninsured
- ☐ My application for Medicaid/ACA insurance was denied
- ☐ I need help getting to other important appointments

Housing

- ☐ I do not have housing (living in shelter, with friends, in a car, in a park, etc.)
- ☐ I would like assistance to find affordable housing
- ☐ I am at risk of losing my housing

Housing (Continued)

- ☐ There are unsafe conditions at my home (mold, leaks, peeling paint, etc.)
- ☐ I have difficulty paying heating/utility bills

Food

- ☐ I sometimes or often do not have enough food for myself and/or my family
- ☐ I would like to apply for Food Stamps (SNAP) benefits
- ☐ I was denied Food Stamps (SNAP)

Transportation

- ☐ I need help going to medical appointments
- ☐ The bus system does not go near where I live or work

Other

- ☐ I would like to register to vote
- ☐ I need help filing my taxes
- ☐ My disability application was denied
- ☐ Other barriers/challenges:

_____

_____

None:

- ☐ I do not need assistance at this time.

Blue Ridge Staff Name_____ Slide (A-E):_____ Entered into EHR (initials)_____