Dr. Robert E. Appleby
School Based Health Centers

Enrollment Form

2016-2017 School Year

CONTENTS

HUMAN SERVICES COUNCIL

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HUMAN SERVICES COUNCIL

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Welcome to the Program

2016-2017 School Year

Dear Parent/Guardian

Welcome to the Dr. Robert E. Appleby School Based Health Centers, a program of the Human Services Council. As a student in one of Norwalk's High Schools or in one of the three middle schools, your child has the opportunity to take advantage of our on-site physical and/or mental health services. Remember, at this time we only offer mental health services at three of the four middle schools. Our goal is to keep students healthy, in the classroom, and ready to learn.

Why use the School Based Health Center?

For all of Norwalk's high school students, we provide easy access to high-quality physical and mental health-care, in a friendly setting, at a time that is convenient. And, this is at no out-of-pocket cost to your family.

What Services do we provide at Norwalk's High Schools?

The staff at each School Based Health Center includes: a Nurse Practitioner or Physician Assistant, Licensed Clinical Social Worker, Office Assistant, Social Work Supervisor, and Program Director. School Based Health Center services are offered when school is in session.

Our staff works with an Adolescent Psychiatrist and Pediatrician, when needed, for consultation and medication assessment. In addition, our staff works closely with school personnel, such as the guidance, social work, and nursing departments to help ensure your child's well-being.

What Services do we provide at participating middle schools?

The staff at each School Based Health Center includes: a Licensed Clinical Social Worker.

Our staff works with an Adolescent Psychiatrist and Pediatrician, when needed, for consultation and medication assessment. In addition, our staff works closely with school personnel, such as the guidance, social work, and nursing departments to help ensure your child's well-being.

Who are your SBHC Staff ?

Anthony DiLauro	**Executive Director**, Human Services Council
Carmen Hufcut	**Program Director,** Dr. Robert E. Appleby School Based Health Centers, a program of the Human Services Council
Elizabeth Ashley	**Office Administrator**, Norwalk Pathways Academy at Briggs High School, 203.846.6385
Ariana Richards, *LCSW*	Norwalk Pathways Academy at Briggs High School, 203.846.6385 x13749
Laurie Kalamaras	**Office Administrator**, Norwalk High School, 203.838.4481 x13340
Jessica Finck, *APRN*	Norwalk High School, 203.838.4481 x13344
Rose Sferlazza, *PA-C*	Norwalk High School, 203.838.4481 x13344
Glenn Shephard, *LCSW*	Norwalk High School, 203.838.4481 x13341
Diamond Sead	**Office Administrator**, Brien McMahon High School, 203.854.0524
Julia Sparkman, *APRN*	Brien McMahon High School, 203.854.0524
Lesley Eisenberg, *LCSW*	Brien McMahon High School, 203.854.0524
Carine Lauterbach, *LCSW*	Nathan Hale Middle School, 203.899.2910 x17213
West Rocks Middle School	LCSW position open
Ponus Ridge Middle School	LCSW position open

HUMAN SERVICES COUNCIL

Welcome to the Program (cont'd)

The medical and mental health services we provide include:

- Diagnosis/Treatment of Acute & Chronic Illnesses
- Comprehensive Physicals
- Immunizations
- Health Screenings
- Basic Laboratory Tests
- Health Education & Health Counseling
- Individual, Group and Family Counseling
- Crisis Intervention
- Support with School Transition
- Support with Social Skills
- Support with Life Transition Issues
- ADHD/ADD
- Crisis Intervention
- Anger Management
- Alcohol & Substance Abuse Prevention
- Anxiety/Stress Management
- Reproductive Health Issues: Screenings, Treatment, Prescribing
- Weight Management and Nutrition Counseling
- Referral and follow-up to medical Specialists, Community Providers, Agencies, and Hospitals
- Prescriptions, Medication Management (including psychiatric medications)
- Psychotherapy, Psychiatric, and Medication Assessment

How do you Participate ?

Enrollment is easy. Simply complete and sign both the attached Consent Form and Medical History Form, and return to the School Based Health Center at your child's school. If you carry health insurance, we ask that you also include a copy of your insurance card. No family will ever have to pay out-of-pocket for our services. If you do not have health insurance or your health insurance does not cover our services, there will be no charge to you.

I am available to answer any questions you may have so please feel free to call me at: 203-849-1111 at the Human Services Council, from 9 am - 5 pm, Monday through Friday.

The staff and I look forward to working with you and your child. Healthy students make better learners.

All the best,

Anthony DiLauro, Executive Director
Human Services Council

Dr. Robert E. Appleby School Based Health Centers	Norwalk Mentor Program	Mid-Fairfield Substance Abuse Coalition	Supportive Housing	Children's Connection

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Registration Form

___ Norwalk HS ___ Brien McMahon HS ___ Briggs HS

___ Nathan Hale MS ___ Ponus Ridge MS ___ West Rocks MS

Please complete all information on the front and back of this registration form. You must sign and date it in order for your student to receive services from the School Based Health Centers. If a student is 18 or older, he/she can sign his/her own registration form.

Grade:_____ **Date of Birth:** _____

Student's Name:_____ Sex: ____ M ____ F

Address: _____ City:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Person:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Would you like to receive email notices from the School Based Health Centers?
If yes, provide email address: _____

Ethnicity of student (Per Federal OMB Guidelines): **Please circle one.**

Hispanic/Latino(a) Not Hispanic/Not Latino(a)

Race of student (Per Federal OMB Guidelines): **Please circle one.**

White Black AmIndian/Alaska Native Native Hawaiian or other Pacific Islander Asian

If Race of student is NOT listed above, kindly write in here: _____

Mother's Name _____ Daytime Phone: _____

Father's Name _____ Daytime Phone: _____

If not parents, with whom do you live? _____ Daytime Phone: _____

Please indicate your relationship to student: Guardian ____ Other _____

Does your child receive Free or Reduced priced Lunch ____ Yes ____ No

Source of Medical Care:

Who is your child's doctor/clinic: _____ Phone: _____

Where do you usually bring your student for medical care?

___ Community Health Center
___ Emergency Room
___ Health Department Clinic
___ Hospital Clinic/Outpatient
___ Military Clinic
___ Private MD
___ School Based Health Clinic
___ Urgent Care Clinic
___ Mobile Van
___ None
___ Other

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Permission Form

Student Name (Print)

I give permission for the student identified in this application to obtain services at the Dr. Robert E. Appleby School Based Health Centers, (REASBHC) while he/she is in school. The permission will remain in effect unless I withdraw it, or if my child/guard is no longer attending Norwalk Public Schools.

I understand that all services provided to the student and records of such are **CONFIDENTIAL** to the student, and will not be released or discussed without written or verbal permission from the student, except in and in accordance with Connecticut State and Federal laws. In the event the student is referred to Norwalk Hospital for evaluation and/or treatment, I give permission to Norwalk Hospital staff to release related treatment information to The Dr. Robert E. Appleby School Based Health Centers.

A copy of the treatment plan should be sent with the student or faxed to the respective School Based Health Center as soon as possible. For services **not** provided by REASBHC, I further understand that the above named student may be referred to community agencies and specialists. Services such as those may **not** be free and therefore, the parent must negotiate fees in advance if these services are recommended and/or needed. Please inform us of any changes such as insurance status, employment, phone numbers, and attach a copy of your current insurance card. **Please provide us with a copy of your insurance card every time you change carriers.**

In signing this permission form, I am acknowledging that I understand the services the REASBHC provides. I have been given the opportunity to ask questions before enrolling my child. I understand and acknowledge that the Norwalk Board of Education ("The Board") has no responsibility or liability for the services rendered by REASBHC and that they are independentlyowned and operated. "The Board" is merely providing space for REASBHC and has no legal relationship with them. We hereby release "The Board", and waive any and all claims, which we may have or make against "The Board" in any way related to or arising out of the REASBHC or any services rendered by them.

Parent/Guardian/Other Signature

Date

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Medical History

Student Name: _____ **Date of Birth** ___ / ___ / ___ **Sex** ____

Does your child have any allergies? ____ Yes ____ No If yes, What? _____

List any medications your child is taking now and the problem for which the medication was given:

Medication	**Reason**	**How Long**

Has your child ever been hospitalized? ____ Yes ____ No

If yes, give the age at time of hospitalization and describe the problem.

Problem	**Age**

Has your child ever had any serious injuries? ____ Yes ____ No If yes, please explain (include date)

_____

_____

Has your child had any of the following:

Y	N		Y	N	
☐	☐	Eating Problems	☐	☐	Heart Problems (Murmur, Rheumatic, Disease)
☐	☐	Sleeping Problems	☐	☐	High Cholesterol
☐	☐	Weight Problems	☐	☐	Stomach Problems (Diarrhea, Constipation, Celiac, Vomiting)
☐	☐	Vision Problems	☐	☐	High Blood Pressure
☐	☐	Hearing Problems	☐	☐	Urinary Tract Infection
☐	☐	Lyme Disease	☐	☐	Menstrual Problems
☐	☐	Skin Disorders (Eczema, Psoriasis)	☐	☐	Significant Injury/Broken Bones
☐	☐	Ear Infections	☐	☐	HIV/AIDS
☐	☐	Asthma	☐	☐	Arthritis
☐	☐	Pneumonia	☐	☐	Seizures
☐	☐	Headaches/Migraines (circle)	☐	☐	Attention Deficit Disorder
☐	☐	Blood Disorders (Anemia, Sickle Cell Disease, Trait Thalessemia Disease or Trait)	☐	☐	Oppositional Defiance Disorder
☐	☐	Depression	☐	☐	Mental Illness
☐	☐	Hernia	☐	☐	Diabetes
☐	☐	Thyroid Problems	☐	☐	Cancer
☐	☐	Mononucleosis	☐	☐	Rheumatic Heart Disease
☐	☐	Meningitis	☐	☐	Sexual or Physical Abuse
☐	☐	MRSA	☐	☐	Hepatitis
☐	☐	Tuberculosis (Contact / Infection)	☐	☐	C-Diff

Please list any concerns you have regarding your child's health: _____

_____

Would you like the SBHC Staff to contact you about these concerns? _____ Y _____ N

Phone : _____

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Medical History (cont'd)

Dental History:

Date of most recent visit to Dentist _____ Reason for visit? _____

Do you have any questions or concerns about your child's oral health ? Yes _____ No _____

If Yes, Please write in question: _____

If we were able to provide dental services, would you be interested ? Yes _____ No _____

Family History:

Please check below if any of your child's relatives (i.e., Parents, brothers/sisters, aunts, uncles, or grandparents) have/had any of the following illnesses and note which relative had them:

Illness	Relative	Explanation
☐ Diabetes, Endocrine Disorder		
☐ Cancer		
☐ Heart Problems/Vascular Disease/Stroke		
☐ High Blood Pressure		
☐ Blood Disorders (including Anemia/Thalessemia)		
☐ Respiratory Problems (including Asthma)		
☐ Mental Illness		
☐ Alcohol/Drug Problems		
☐ Infections (TB / HIV / AIDS)		
☐ Death under the age of 50		
☐ Liver/Kidney Problems		

I have read the materials supplied to me regarding the services of the Health Centers and give permission to the above named student to obtain medical and/or mental health services offered at the Dr. Robert E. Appleby School Based Health Centers (REASBHC) while he/she is in school. Furthermore, I give permission to the Health Centers to release information regarding treatment and/or services to insurance providers for the purpose of billing, if applicable. I authorize insurance payments to be made directly to the REASBHC for services provided.

_____ _____ _____

Name of person completing this form | Date | Relationship to Student

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Notice of Privacy Policy

Effective: August 1, 2013

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please read carefully.

HSC's Dr. Robert E. Appleby School Based Health Centers are required by law to protect certain aspects of your health care information known as Protected Health Information (PHI) and to provide you with this Notice of Privacy Practices.

This Notice describes our privacy practices, your legal rights and lets you know how HSC - SBHC is permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restriction on our use and disclosure of your PHI

In most situations we may use this information described in the Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all healthcare information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

If you have any questions, contact our Program Director, Carmen Hufcut, at HSC 203-849-1111 x3003.

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how HSC - SBHC is permitted to use and disclose PHI about you.

We use and disclose PHI in many ways:

- **For treatment.** This includes such things as verbal and written information that we obtain about you and use pertaining to medical conditions and treatment provided by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment). We also may share PHI in order to coordinate the different services you need: prescriptions, lab work and diagnostic testing. We also may disclose PHI to people who may be involved in your medical care such as family members, etc.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the SBHC may be billed for and payment may be collected on your behalf from an insurance company or third party.
- **For Health Care Operations.**This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, creating reports that not individually identify you for data collection purposes.

Use and Disclosure of PHI without Your Authorization

HSC - SBHC is permitted to use PHI without your written authorization, or opportunity to object in certain situations, including:

- For HSC-SBHC's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your insurance company);
- To another health care provider (such as the hospital to which you are transported) for the health care operations activities of the covered entity that received the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or when required to do so by federal, state ,or local law;
- To avert a serious threat to health or safety.

HUMAN SERVICES COUNCIL

Notice of Privacy Policy (cont'd)

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to inspect and copy medical and billing records.** This does not include psychotherapy notes. To inspect and copy medical information you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. HSC will provide you with a written denial; specifying the legal basis for the denial, a statement of your rights and a description of how you may file a complaint with us.
- **Right to Amend.** You have the right to request an amendment of your PHI for as long as the designated record is maintained by HSC. Your request must be in writing, providing the reason that supports your request. We may deny the request if you ask us to amend information not created by us; is not part of the medical information kept by or for the SBHC; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, excluding disclosures for the purpose of treatment, payment or healthcare operations. This request must be submitted in writing to the Administrator including time period requested.
- **Right to Request Restrictions.** You have the right to request in writing, a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. This includes a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member.
- **Right to Request Confidential Communication.** You have the right to request, in writing that we communicate with you about medical matters in a certain way or at a certain location. Your request must include how and where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to follow your request.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right to Breach Notification.** You have the right to be notified of any breach of your unsecured information healthcare.

Other Uses of Medical Information

For all other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization. If you provide permission to us to disclose PHI about you, you may revoke that permission, in writing at any time.

Complaints

If you believe your privacy rights have been violated, you may submit your complaint in writing to HSC:

Carmen Hufcut, Program Director
Dr. Robert E Appleby School Based Health Centers
Human Service Council
One Park Street, Norwalk CT 06851

CHANGES TO THIS NOTICE

We reserve the right to amend or revise this Notice at any time. The revised or amended Notice may be made effective for all PHI HSC maintains as well as any information we received in the future. We will post a copy of the current notice in our office which will contain the effective date.

HUMAN SERVICES COUNCIL

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Consent & Acknowledgement Form

Please sign this form and return to your child's school based health center

I consent to the use or disclosure of protected health information by HSC's Dr. Robert E. Appleby School Based Health Centers, to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information. I understand that further information regarding how HSC's Dr. Robert E. Appleby School Based Health Centers will use and disclose protected health information can be found in his Notice of Privacy Policy.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent, and
- I have received HSC's Dr. Robert E. Appleby School Based Health Centers Notice of Privacy Policy currently in effect.

_____ I give permission for the Dr. Robert E. Appleby School Based Health Center to speak with school staff in order to provide the best care for my child. (please initial)

_____

Print Name of Individual or Personal Representative

_____ _____

Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

For Office Use Only:

Unable to obtain written consent and acknowledgement because:

_____ Individual refused

_____ Emergency treatment situation

_____ Individual not able to sign due to incompetence or other medical reason

_____ Other: _____

HUMAN SERVICES COUNCIL

Insurance Verification

Student Name: _____ **Date of Birth** ___ / ___ / ___ **Sex** ____

- Please provide a copy of your current Insurance Card(s), Medicaid Card, Medicaid Managed Care Plan Card and any claim form(s) your insurance carrier requires.
- Type of Insurance (check all that applies and complete information below on your child's coverage).

Primary Insurance

Carrier Name: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's D.O.B. _____

Employer: _____ Employer Phone: _____

Effective Date of Coverage: _____

Does the child have Medicaid ____ Yes ____ No If yes, please provide Medicaid # _____

Have you enrolled in Medicaid Managed Care ? ____ Yes ____ No
If yes, indicate below the name of the Plan.

_____

I authorize the release of any medical information or other information necessary to process appropriate claims for health insurance for covered services under my policy. I also authorize the payment of medical benefits to the School Based Health Center.

_____ _____ _____

Signature (person completing this form) Relationship to Student Date