SBHC Enrollment Packet
Age 1-12 English

Dear Bethel Parents/Guardians:

Your child can now receive healthcare right at school!

Bethel School District is proud to announce the opening of a school-based health center (SBHC) at the Bethel Learning Center. It is operated independently by Community Health Care (CHC), a local community health center that serves Pierce County. The SBHC will provide primary medical care, dental care, and mental health counseling to district students and staff.

The SBHC is open to all students enrolled in the Bethel School District, grades K-12 and employees of the school district. Provided healthcare services will include:

- Vaccinations
- Annual well-child checks and sports physicals
- Evaluation and treatment of illness and injuries
- Treatment of chronic conditions such as asthma or diabetes
- Prescription medications
- Dental care (exams, x-rays, cleanings, fluoride, sealants, fillings for cavities, etc.)
- Vision screening
- Mental health care (screening and counseling for depression, anxiety, substance abuse, etc.)
- Confidential services per WA state law
- Health education
- Referrals to other healthcare specialists if needed

The SBHC can see your child even if you do not have insurance or can't pay.

- If you have insurance, CHC will bill your insurance for services.
- If you do not have insurance, CHC can assist you in getting low- or no-cost health insurance.
- If you are unable to get insurance for any reason, or if you have insurance but still cannot afford the cost of care, CHC will provide low-cost care on a sliding fee scale based on your income.

CHC will not refuse service to **any** student, regardless of family circumstances or inability to pay.

You need to enroll your child at the SBHC in order for them to use these services. The SBHC can be your child's healthcare home for all their medical, dental and behavioral health needs.

To enroll in the SBHC, please complete and sign the following forms in this enrollment packet:

Patient Registration Form
SBHC Consent Form
Notice of Insurance Eligibility
Health History
Application for Sliding Fee

Please return the enrollment packet to the SBHC at 21818 38th Ave E, Spanaway, WA 98387 (Bethel Learning Center). Paper versions of the packet are available at the SBHC.

Bethel School District is fortunate to have a school-based health center, because ***healthy kids learn better***! If you would like more information about the SBHC and its services, call **253-722-1718** or stop in and meet the SBHC staff!

Sincerely,

Tom Seigel, Bethel School District Superintendent

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School-Based Health Center in the Bethel School District

What is a School-Based Health Center (SBHC)?

- A school-based health center is a clinic located in the school or on the school property that provides full-spectrum family medical, dental and behavioral health services. Students can avoid missing school when sick and get support to succeed in their classroom by having quick and consistent access to health care while at school. The Bethel School District SBHC is operated by Community Health Care and follows state and federal laws, policies, procedures and professional standards of medical, dental and behavioral health care. With a pre-signed parental consent, students can access health care during typical school hours.

Who can use the School-Based Health Center?

- Any student from any Bethel School District school who is enrolled in the SBHC may get services, as well as any Bethel School District staff member.

Where is the School-Based Health Center located?

- Starting September 11, 2019, a temporary clinic site will be located at the Bethel Learning Center. The permanent health center opens at Bethel Middle School in Spring 2020.

Who staffs the School-Based Health Center?

- SBHCs are staffed by a team of certified health professionals that may include: a Family Practice Physician, Advanced Registered Nurse Practitioner, Physician Assistant – Certified, General Dentist, Behavioral Health Specialist, Registered Nurse, Dental Assistants, Medical Assistants, receptionists and insurance enrollment specialists.

What are the hours of the SBHC? **8am - 5pm Monday – Thursday!**

- The SBHC is open year-round with limited summer hours.
- Services available:
  - Medical: Monday & Wednesday
  - Dental (walk-ins available): Tuesday
  - Walk-in nurse consultation visits: Tuesday & Thursday
  - Behavioral health: Coming in October (Monday through Thursday)

Do students need to have parental permission to visit the SBHC? YES!

- Parents or legal guardians must pre-sign consent forms for their child to get care. Under WA State Law, all students can receive emergency medical care without parental consent. Children 13 years and older can get confidential services per Washington State law; and mental health and substance abuse treatment without parental consent. Students getting these services are always encouraged to discuss health concerns with safe parents/guardians.
- If there is an urgent issue, SBHC staff may call the parent to get verbal consent to treat the child.

"To provide the highest quality health care with compassionate and accessible services for all"

Can parents attend their child's appointment? YES!

- Parents/guardians are always encouraged to participate directly in their child's care, but if you have trouble getting time off or cannot attend the appointment (and a pre-signed consent is on file), we can see your child during the school day and call you after the appointment with an update.

Can students attend appointments during class time? YES!

- SBHCs are focused on helping students stay in school and learn. Every effort is made in SBHCs to schedule appointments so students do not miss core classes.

If my child is sick at home, can they be brought to the SBHC to be seen? YES!

- Any student enrolled in the SBHC can been seen at any time by any of our medical, dental, and behavioral health providers.

How is a student enrolled in the SBHC?

- Parents or legal guardians must complete and return a Parent Consent Packet. Only students who are enrolled in the SBHC can be seen in the SBHC. Parent Consent Packets can be found at https://www.commhealth.org/sbhc

Does a student need to have health insurance to be seen at the SBHC? NO!

- SBHCs provide care to students whether or not they have insurance. Private and state insurances will be billed for services when appropriate. A sliding fee scale is available for families who are under-insured or uninsured. The sliding fee scale is based on household income and family size. No student will be turned away for the lack of ability to pay. An insurance enrollment specialist is an important part of the SBHC team and can assist with finding an insurance plan that fits your family and financial needs.

Does my child's school still have a school nurse? YES!

- A SBHC does not replace the very important role of a school nurse. By working with the school nurse, additional and quicker resources can be available for students with medical, dental and/or behavioral health needs. If your child becomes ill during the school day, he/she will still go to the school nurse office and the nurse will call you. The nurse will then ask if you want your child to be seen at the SBHC.

Can my child be seen if we already have a primary care provider (PCP)? YES!

- A student can be enrolled in the SBHC and keep their regular PCP. The SBHC will always send copies of visits to your child's regular provider. If your student does NOT have regular PCP, you can enroll your child and use the SBHC as your child's primary care provider. As a CHC patient your child would be welcome to access any of Community Health Care's primary care clinics, dental clinics, specialty clinics, urgent cares and pharmacies. A full list of CHC resources can be found at http://www.commhealth.org

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Patient Information

Last Name _____ **First Name** _____ **Middle Initial** _____ **Preferred Name** _____

Social Security Number _____ **Birth Date** _____

Gender Assigned at Birth: ☐ Male ☐ Female

Current Legal Gender: ☐ Male ☐ Female ☐ Undifferentiated

Gender Identity: ☐ Prefer not to answer ☐ Male ☐ Female
☐ Male-to-Female ☐ Female-to-Male ☐ Other: _____

Sexual Orientation: ☐ Prefer not to answer ☐ Straight ☐ Lesbian/gay ☐ Bisexual
☐ Other:

Preferred Pronoun: ☐ Prefer not to answer ☐ He/Him/His ☐ She/Her/Hers
☐ They/Them/Theirs ☐ Ze/Hir ☐ Other: _____

Physical Address _____ Mailing Address (if different than physical) _____

City _____ **State** _____ **ZIP Code** _____ City _____ State _____ ZIP Code _____

Marital Status: ☐ Widowed ☐ Married ☐ Single ☐ Divorced

Student Status: ☐ Full time ☐ Not a student ☐ Part time

Primary Language _____ **Would an interpreter be helpful for your visit?** ☐ Yes ☐ No

☐ **I have a primary doctor** ☐ **I have a primary dentist**

Patient Contact Information

Home Phone _____ **Daytime Phone** _____ **Email address*** _____

Preferred contact number: ☐ Home Phone ☐ Daytime Phone
☐ **You have my permission to leave a detailed message on my preferred phone**

How would you like to receive appointment reminders? ☐ Email ☐ Phone call ☐ Text ☐ Voicemail

Emergency Contact Name _____ **Relationship** _____ **Phone #** _____

Patient Additional Demographics (UDS)

If homeless, shelter type: ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional
☐ Other: _____ ☐ Unknown

For Agricultural Workers: ☐ Seasonal ☐ Migrant

What ethnicity do you consider yourself? ☐ Cuban ☐ Chicano/a ☐ Mexican
☐ Mexican American ☐ Puerto Rican ☐ Another Hispanic, Latino/a or Spanish origin
☐ Not Hispanic, or Latino/a or Spanish origin ☐ Prefer not to answer

What race do you consider yourself? ☐ American Indian/Alaskan Native ☐ Asian Indian
☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hawaiian Native ☐ Japanese ☐ Korean ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White
☐ Prefer not to answer

Have you served in the United States military, armed forces or uniformed services? This includes: Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA). ☐ Yes ☐ No

What is your preferred pharmacy? (name and location) _____

**Community Health Care will not sell or rent your email address, name, mailing address, or other supplied information to anyone. Community Health Care will not share your email address, first or last name, mailing address, or other received information with anyone, except: we may disclose personally identifiable information about you as legally required in order for us to respond to subpoenas, court orders, or other legal processes.*

Responsible Party Information (if different than above) ☐ Same as above

Last Name _____ First Name _____ Middle Initial _____ Preferred Name _____

Social Security Number _____ Birth Date _____

Gender Assigned at Birth: ☐ Male ☐ Female

Current Legal Gender: ☐ Male ☐ Female ☐ Undifferentiated

Gender Identity: ☐ Prefer not to answer ☐ Male ☐ Female
☐ Male-to-Female ☐ Female-to-Male ☐ Other: _____

Sexual Orientation: ☐ Prefer not to answer ☐ Straight ☐ Lesbian/gay
☐ Bisexual ☐ Other: _____

Preferred Pronoun: ☐ Prefer not to answer ☐ He/Him/His ☐ She/Her/Hers
☐ They/Them/Theirs ☐ Ze/Hir ☐ Other: _____

Physical Address _____ Mailing Address (if different than physical) _____

City _____ **State** _____ **ZIP Code** _____ City _____ State _____ ZIP Code _____

Marital Status: ☐ Widowed ☐ Married ☐ Single ☐ Divorced

Student Status: ☐ Full time ☐ Not a student ☐ Part time

Primary Language _____ **Would an interpreter be helpful for your visit?** ☐ Yes ☐ No

☐ **I have a primary doctor** ☐ **I have a primary dentist**

Responsible Party Information Contact Information

Home Phone _____ **Daytime Phone** _____ **Email address*** _____

Preferred contact number: ☐ Home Phone ☐ Daytime Phone
☐ **You have my permission to leave a detailed message on my preferred phone**

How would you like to receive appointment reminders? ☐ Email ☐ Phone call ☐ Text ☐ Voicemail

Emergency Contact Name _____ **Relationship** _____ **Phone #** _____

Responsible Party Additional Demographics (UDS)

If homeless, shelter type: ☐ Doubling up ☐ Shelter ☐ Street ☐ Transitional
☐ Other: _____ ☐ Unknown

For Agricultural Workers: ☐ Seasonal ☐ Migrant

What ethnicity do you consider yourself? ☐ Cuban ☐ Chicano/a ☐ Mexican
☐ Mexican American ☐ Puerto Rican ☐ Another Hispanic, Latino/a or Spanish origin
☐ Not Hispanic, or Latino/a or Spanish origin ☐ Prefer not to answer

What race do you consider yourself? ☐ American Indian/Alaskan Native ☐ Asian Indian
☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hawaiian Native ☐ Japanese ☐ Korean ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White
☐ Prefer not to answer

Have you served in the United States military, armed forces or uniformed services? This includes: Air Force, Army, Coast Guard, Marines, Navy, Space Force, National Guard, or Reserves or the US Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA). ☐ Yes ☐ No

How Did You Hear About Us?

☐ Tacoma/Pierce County Health Department
☐ Hospital—which one? _____
☐ Other: _____
☐ Needle Exchange Program
☐ Outreach Worker
☐ CHC Employee
☐ CHC Patient

Primary Insurance Information

_____
Name of Insurance Company

_____
Insurance claims Address

_____
Policy Holder Name

Accident? ☐ Yes ☐ No ☐ Work ☐ Auto

Auto Accident?

_____
Policy ID Number

_____
Birth Date

_____
Date of accident

On-the-Job Injury?

_____
Group Number

_____
Effective Date

_____
Relationship to Patient

_____
Claim number or date of injury

Authorization, Consent and Assignment of Benefits

I hereby consent to outpatient care with Community Health Care with a multidisciplinary team of clinicians. This care may include: Evaluation, Diagnostic, Consultation and Treatment for Medical, Psychiatric, Behavioral Health and/or Dental care. These services may be delivered in one of our clinics or through a telemedicine system, using video conferencing equipment. I authorize my insurance benefits to be paid directly to Community Health Care and understand that I am financially responsible for all non-covered services. I agree to the release of information regarding Treatment/Consultation for Medical, Psychiatric, Behavioral Health and/or Dental care for the purpose of payment or health care operations. This authorization and assignment is permanent and will remain on file and be used for future claims. I may revoke it at any time by written notice. I acknowledge that I have received a copy of the Notice of Privacy Practices for Community Health Care.

☐ I understand that Community Health Care will bill me and/or my insurance for in person, audio-visual, and audio-only medical, dental and/or behavioral health visits.

Is there anyone you would like us to share your **general** medical/dental information with?

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Signature: _____ Date: _____

Relationship to patient (if the patient is a minor or has a guardian): _____

For Office Use Only:

☐ Patient Declined Sliding Fee ☐ Patient Declined Sliding Fee and Income Range Declaration Initials _____

Community Health Care
Supplemental School Based Health Center Consent for Services Form

_____ _____

Full Name of Student **Date of Birth**

_____ _____

School **Grade**

The school-based health center (SBHC) is a Community Health Care (CHC) clinic. If I enroll my child at the SBHC, he or she becomes a registered patient with CHC and may access services at any CHC clinic. I understand that the SBHC Medical Provider may be my child's designated primary care provider. If my child is not enrolled at the SBHC, they can continue to receive school nurse services.

Services at the SBHC may include, but are not limited to: vaccinations, annual well-child checks, sports physicals, evaluation and treatment of illnesses and injuries, treatment of chronic conditions, medicine, dental care, vision screening, mental/behavioral health care, health screenings/counseling/education, and/or referrals to other healthcare specialists. Additional comprehensive services may be found at other CHC clinics. A full list of CHC locations can be found at www.commhealth.org.

By marking yes I consent to the following services:

☐ **Yes!** I consent for my child to receive **medical care** including behavioral health services through the CHC School Based Health Center.

☐ **Yes!** I consent for my child to receive **dental care** through the CHC School Based Health Center. Examples: fillings, extractions, space maintainers, cleanings, x-rays, sealants, fluoride application.

Medicines/Vaccines:

I permit SBHC providers to administer over-the-counter medications (such as Tylenol) to my child. I understand that SBHC providers will contact me to obtain specific verbal consent before administering a prescription medication to my child. **Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian**.

____ **(initial) I do NOT want CHC to give my child any over-the-counter medicine without specific verbal consent from a parent/guardian.**

____ **(initial) I do NOT consent to SBHC staff giving vaccines to my child.**

Appointments:

I understand that a parent/guardian can make appointments for my child at the SBHC. I can choose whether or not to be present during these appointments. If I am not present, authorization is given for my child to receive services in my absence. The SBHC providers will contact me via phone for verbal permission to provide treatment when it is not an emergency. If my child has a medical emergency, CHC SBHC providers will treat per Washington state law or call 911.

Text Communications:

Students and/or parent/guardian can text the clinic to make an initial appointment. I permit CHC to communicate with me/my child via unencrypted text message for the sole purpose of scheduling and confirming appointments. CHC will never discuss or disclose any personal health information with me/my child via unencrypted text. Once

my child is enrolled as a CHC patient, I/they can communicate with their provider through a free, encrypted text-messaging app.

Release of Information

I hereby allow the SBHC to disclose to the Bethel School District whether my middle or high school student is present at any given time at the SBHC. The purpose of this disclosure is so that my student's school can account for my student's unescorted travel between the school and the SBHC, permission for which may be allowed or withheld by the District in its sole discretion. Disclosure of this information by the SBHC to the District will NOT include protected health information regarding my student. (Note: Elementary students will be escorted when traveling between the school and the SBHC).

I also authorize CHC to release medical records to my child's other health care providers as needed to assist in the treatment and/or continuity of care for my child. These records may include but are not limited to the following: immunization records, results of sports physicals, medical and behavioral health conditions, medications, and treatment plans. The medical and mental health providers from the CHC SBHC may participate in my child's school success or attendance teams if needed. I also authorize my child's other health care providers to release information to the CHC SBHC staff members as needed.

By signing this consent, I confirm I am the parent/legal guardian of the student listed above and am authorized to give this consent. This consent will be in effect for one year from this date.

_____ _____

Student Signature Date

_____ _____

Parent Signature Date

Preferred phone number of guardian for urgent daytime contact: _____

IMPORTANT ADDITIONAL INFORMATION

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist. For example:

- When permission is given by the patient through a signed release of information.
- When the patient indicates risk of imminent harm to self or others.
- When the patient has a life-threatening health problem and is under 18 years old.
- When there is reason to suspect abuse or neglect.
- Certain communicable diseases must be reported to public health authorities

Community Health Care School-Based Health Centers encourage each student to involve their parents or guardians in health care decisions whenever possible. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Also, starting at age 13, youth may independently receive drug and alcohol cessation services and mental health counseling without parent/guardian consent. Starting at age 14, youth may independently receive testing and/or treatment for HIV and STIs. Because youth may independently receive this care, their consent is legally required for release of information about pregnancy and sexually transmitted infections. Consent from students age 13 and over and parent/guardian consent for students age 12 and under is legally required for release of information about alcohol and drug or mental health counseling. RCW 26.28.010, RCW 7.70.050(4), RCW 70.24.110, RCW 9.02.100(1), RCW 71.34.530, RCW 71.34.510, RCW 70.96A.230, and RCW 70.96A.096.

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Application For Sliding Fee

In order to meet the requirements of our Federal grant, we must collect income information on all patients. In order to qualify for sliding fee payments (for uninsured patients and those whose insurance may not pay for all services), you must fill out the information below.
If you are uninsured, you must also meet with a staff member to determine if you qualify for insurance before your second visit.

How many people are supported by this income? _____

Use the number of persons in your family who live in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents. Please list the people you have included:

NAME	RELATIONSHIP TO YOU	NAME	RELATIONSHIP TO YOU
_____		_____	
_____		_____	
_____		_____	

How much MONTHLY gross income in your household comes from:

Employment	_____	Disability	_____
Unemployment	_____	Pension Funds	_____
Social Security	_____	VA Benefits	_____
Spousal Support	_____	Public Assistance	_____
Scholarship/Grants	_____	Housing Allowance	_____
Military Family Allotments	_____	Other	_____

TOTAL MONTHLY INCOME **$**_____

To the best of my knowledge, the information given is true and correct. I give Community Health Care permission to verify information about my financial status. I understand that I must provide proof of this information by my next visit or within 30 days (whichever is first) in order to qualify for sliding fee scale. If this information is not received, then I will be billed at full fee for the visit.

_____	_____	_____
Patient or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date
_____	_____	_____
Patient or Parent/Guardian DOB	Staff member signature	Date

For Office Use Only:

☐ **See child's chart**

Annual Income $_____ # in Household _____ Sliding Scale Level _____ Initials _____

Insurance eligibility:

- ☐ Patient was not eligible for insurance (accept sliding fee per declaration on application and change sliding fee expiration date to 1 year from declaration)
- ☐ Patient eligibility is pending (patient has or is applying with Navigator; accept sliding fee per declaration on application and change sliding fee expiration to 1 month from date of declaration until eligibility determined); this can be extended for another month if insurance is still pending.
- ☐ Patient was eligible but chose not to accept insurance or meet with navigator (patient must bring in proof of income per policy: check stubs for past month, tax return, or other approved form)
- ☐ Patient currently has insurance or is eligible and now has insurance (sliding fee per declaration on application; change sliding fee expiration date to 1 year from declaration)
- ☐ Patient no showed or cancelled navigator appointment, was unable to enroll due to enrollment period, or chose not to accept navigator appointment (patient must bring in proof of income)

(Form is scanned into patient record)