Family Medical Care School Based Health Center

SBHC is a division of CHANGE, Inc. CHANGE, Inc. is an equal opportunity provider & employer.

CHANGE, INC.

Administrative Office
3158 West Street
Weirton, WV 26062
304-797-7733 www.changeinc.org

School Based Health Center Locations

Brooke County
Indian Creek Middle
Indian Creek High
Steubenville City
Toronto
Weir Complex
Weirton Elementary

Student Name: ____ Birth Date:______/_____/_______

Student's Family Doctor: ____________________________________ Phone: (_____)_____-___________

Does your child wear eye glasses? □ Yes □ No Is your child exposed to second hand smoke? □ Yes □ No

Preferred Pharmacy:________________________________

List Medications taken on a daily basis:

Name: _____________________________ mg________ Frequency:________________________________

Name: _____________________________ mg________ Frequency:________________________________

Name: _____________________________ mg________ Frequency:________________________________

Please list any Chronic Health Problems, Previous Hospitalization, or Surgery:__________

____

____

____

Allergies (If yes, please list):

Food: _____No ____Yes If yes,____

Medication: _____No ____Yes If yes,____

Bees: _____No ____Yes If yes,____

Has your child had any history of or difficulty with any of the following? (check if yes):

___ AIDS/HIV
___ Anemia
___ Asthma
___ Bed Wetting
___ Birth Defects
___ Bladder Problems
___ Bleeding, Excessive
___ Cancer
___ Cerebral Palsy
___ Chicken Pox
___ Constipation/Diarrhea
___ Convulsions
___ Depression
___ Diabetes
___ Drugs/Alcohol
___ Ear Infections
___ Epilepsy
___ Fainting
___ Hearing Problems
___ Heart Problems
___ Hepatitis
___ Kidney Disease
___ Lead Poisoning
___ Measles
___ Mononucleosis
___ Mumps
___ Pneumonia
___ Rheumatic Fever
___ Sinus Problems
___ Speech Problems
___ Thyroid Disease
___ Tuberculosis
___ Urinary Disease
___ Vision Problems
___ Worms
___ Other:____________________

When was your last Well Child Visit: __________________________

The information that I have provided is accurate to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian Signature: ____ Date:__________________

Please read carefully and fill out the consent form below for your child to be seen at the Health Center.

All Information is confidential.

Family Medical Care School Based Health Center

SBHC is a division of CHANGE, Inc. *CHANGE, Inc. is an equal opportunity provider & employer.*

CHANGE, INC.

Administrative Office
3158 West Street
Weirton, WV 26062
304-797-7733 www.changeinc.org

School Based Health Center Locations

Brooke County
Indian Creek Middle | Steubenville City | Weir Complex
Indian Creek High | Toronto | Weirton Elementary

Student's Name:____ Grade: ___________
First name *Last Name* *Middle Initial*

Birth Date:_____/_____/______ Gender: ☐ M ☐ F Social Security #: _____/_____/________

Race: ______________ Ethnicity: ☐ Non-Hispanic ☐ Hispanic Preferred Language:_________________

I authorize a physician assistant, physician, or designated health professional to provide necessary and/or advisable treatment for my child. I authorize release of written and verbal information relevant to my child's health care between the school nurse and the health center's staff only when necessary for his/her care. In case of emergency, every effort will be made by the health center staff to notify the parent/guardian. I understand the acknowledgement of Notice of Privacy Practices and know my minor child's rights as a patient of the Weir Complex School Based Health Center.

I authorize the health center to release information regarding treatment to third party payer such as Medicaid or insurance for the purposes of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to the Family Medical Care CHC. I am financially responsible for non-covered services, but understand that services will not be denied due to inability to pay.

Student's Home Address: ______________________________ City:___________________ State: _____ Zip:_________

Parent/ Guardian's Name: ____Preferred Phone #: (_____)_____-______

Relationship to Patient: ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other_________________________________

Housing Status: ☐ Not Homeless ☐ Homeless Shelter ☐ Public Housing (Not Including Section 8)

☐ Other:______________ ☐ Transitional Email Address of Parent/Guardian:_______________________

Name of Emergency Contact in case parent/guardian cannot be reached: ______________________________________

Relationship to Child: ___________________________ Phone #: (_____)_____-______

Parent/Guardian Signature: ____ ***Date:*** ______________

Insurance Information: Please send a copy of the insurance/medical card (if possible).

Mother/Guardian: _____________________________ Birth Date:_____/_____/______

Mother's SSN: _____/_____/________ Cell #: (_____)_____-______ Home/Work #: (_____)_____-______

Father/Guardian: _____________________________ Birth Date:_____/_____/______

Father's SSN: _____/_____/________ Cell #: (_____)_____-______ Home/Work #: (_____)_____-______

Private Insurance

Name of Insurance Company: ____

Address: ___________________________________ City:__________________ State: ______ Zip:_________

Phone #: (_____)_____-______ Employer/Company Name: ___________________________________

Name of Insured Employee: ___________________________ Birth Date:____/____/_____ SSN: ____/____/______

Policy Number: ________________________ Group Number: _______________________

MEDICAID

1. __________ Straight Medicaid (Molina) ______________________________________
2. __________ Unicare ID Number (begins with a "W") ______________________________
3. __________ Health Plan ID Number (begins with an "H") ___________________________
4. __________ Carelink ID Number ____
5. __________ WV Family Health Plan ____
6. __________ CHIP ID Number ___________________________________ Co-Pay $____________

______ No Insurance / Private Pay (A sliding fee scale is available for families that are uninsured. Charges are based on income and family size. A copy of the parent/guardian's proof of income must be on file with the application in order to be eligible). ***Please call our Change Inc. health benefits coordinator at 304-797-7733 for more information.***

Family Medical Care School Based Health Center

SBHC is a division of CHANGE, Inc. *CHANGE, Inc. is an equal opportunity provider & employer.*

Administrative Office
3158 West Street
Weirton, WV 26062
304-797-7733 www.changeinc.org

School Based Health Center Locations

Brooke County
Indian Creek Middle
Indian Creek High
Steubenville City
Toronto
Weir Complex
Weirton Elementary

Child Informed Consent Form

I, ________________________________, the parent/guardian of ________________________________,
(Parent/Guardian's Name) (Minor's Name)

grant permission to utilize the medical, dental, and/or behavioral health services offered through the school-based health center.

Initialing each line and/or signing below, you acknowledge all of the following:

________ **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**
(Initial) In general, any information that is about your health care you receive, or payment for that care, is considered confidential and protected by our practice. We may use your Protected Health Information to carry out treatment, payment, health care operations, and/or other purposes. Our "Notice of Privacy Practices" provides a more complete description of permitted uses and disclosures.

________ **ASSIGNMENT AND RELEASE OF BENEFITS**
(Initial) I hereby authorize payment directly to CHANGE, Inc.'s Family Medical Care, for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, co-pays, and deductibles, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

________ **PATIENT LIABILITY FOR NON-COVERED/INELIGIBLE SERVICES**
(Initial) I understand that the service I will be provided with via my Healthcare Provider or office staff may or may not be covered by my insurance. I understand that it is my responsibility to know my individual insurance plan's covered services, and that CHANGE, Inc.'s Family Medical Care is not responsible to know whether my insurance will pay or require prior-authorization.
If any services I receive at the facility at any time during my course of treatment are deemed non-covered or ineligible or any other reasons unpaid, as well as all efforts are made to obtain payment from my insurance, I understand I am financially responsible for payment of the denied services.

________ **ELECTRONIC RECORD TRANSFER**
(Initial) I understand that it may be necessary to transmit my medical records/prescriptions electronically and I authorize to do so. I understand that if I need to transfer my medical records, that I am required to sign a separate Authorization to Release form with the Medical Records department. I absolve CHANGE, Inc.'s Family Medical Care, and its personnel of any liability relating to the transfer of said records.

________ **AUTHORIZATION TO TREAT**
(Initial) I hereby authorize any provider employed as part of CHANGE, Inc.'s Family Medical Care Health Centers, to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient which may or may not be myself.

________ **AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION**
(Initial) I hereby authorize CHANGE, Inc.'s Family Medical Care to exchange health and education records (including immunization records) with the appropriate school district for the purpose of providing care and treatment, if applicable.

Family Medical Care School Based Health Center

SBHC is a division of CHANGE, Inc. *CHANGE, Inc. is an equal opportunity provider & employer.*

Administrative Office
3158 West Street
Weirton, WV 26062
304-797-7733 www.changeinc.org

School Based Health Center Locations

Brooke County
Indian Creek Middle
Indian Creek High
Steubenville City
Toronto
Weir Complex
Weirton Elementary

HIPAA RELEASE: **I hereby authorize CHANGE, Inc.'s Family Medical Care Health Centers, providers and/or staff to discuss my medical information with the following person(s); This does not allow the release of records to this person(s):**

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Patient's/Guardian's Signature **Date**

Relationship to Patient

Family Medical Care School Based Health Center

SBHC is a division of CHANGE, Inc. *CHANGE, Inc. is an equal opportunity provider & employer.*

Administrative Office
3158 West Street
Weirton, WV 26062
304-797-7733 www.changeinc.org

School Based Health Center Locations

Brooke County		
Indian Creek Middle	Steubenville City	Weir Complex
Indian Creek High	Toronto	Weirton Elementary

Dear Parent and Guardians,

The staff at the CHANGE, Inc.'s Famliy Medcial Care School Based Health Centers are excited to assist your children with all of their health care needs Monday through Friday from 7:00 AM to 3:00 PM. Our licensed healthcare staff is on site in a safe, child-friendly environment. We closely work with the school nurse and faculty to provide convenient care to your child.

So what services are available?

Well check exams, sick visits, injury treatment, immunizations, allergy shots, ADHD evaluation and treatment, sports physicals, behavioral health, dental care, chronic health care maintenance- like being on site to assist with Diabetes, Seizures, and Asthma. Just think of us as a doctor's office inside the school.

So how does it work?

Parents can schedule appointments for their child before, during, or immediately after school. We welcome parents at the appointment, but a child can be seen without you present at your request. We recognize that parents work and there are transportation issues that create barriers to healthcare. We are more than happy to communicate with you via phone after seeing your child. So for example, the school nurse calls home stating that your child came to her with an earache. With your permission, the nurse can bring your child right over so we can evaluate to see if an infection is present. You can also call us or send a note to have your child's teacher send him/her down to us for a visit as well.

What dental services are offered?

Our dentists schedule weekly appointments at our affiliated sites for a range of services which include cleaning, x-rays, state required dental assessments, and applying sealants to teeth.

How does the Behavioral Health Services work?

We have individual counseling on-site provided by a licensed behavioral health specialist. A referral can be provided from the parent/guardian, our healthcare providers, your local healthcare provider, or school staff. Some children have chronic issues like depression or anxiety, others have lost loved ones and need grief support, and others have been through personal crises like divorce or abuse. Our specialist can also assist with management of ADHD or disruptive behaviors such as arguing with adults and defiant behavior. An individualized plan will be developed for each situation.

What about my current doctor's office?

We encourage all families to maintain a relationship with your current doctor. We understand however that it isn't always convenient or possible to get your child to their office on short notice and we can help fill that gap.

What about cost?

All children enrolled in the school-based health services program are eligible to receive service regardless of insurance status. For children insured by CHIP or Medicaid, the services are covered 100% (no charge). We accept most insurance plans. Our rate is the same as a physician office, which is likely less than urgent care and emergency room visits on most insurance copays. If you have no insurance, please ask about the CHANGE Inc. discount program.

How do I enroll my child?

Our goal is to have your child enrolled in the SBHC to help alleviate any barriers to receive healthcare. We will not be able to provide any services without your permission. The forms are to gather medical history and allow us the information to serve your child. You never know when an urgent health concern will arise. In order to obtain enrollment forms, you can stop in the office, call us to have them sent home with your child, or download at www.changeinc.org.

We look forward to meeting you and your children. We welcome you to stop by to ask questions and meet our staff. For questions please call 304-797-7733.

FAMILY MEDICAL CARE COMMUNITY HEALTH CENTER
CHANGE, INC.
Behavioral • Dental • Family & Women's Health • Pediatrics • Vision

FMCCHC is a division of CHANGE, Inc.
CHANGE, Inc. is an equal opportunity provider & employer.

FMC Main Office
3136 West St.
Weirton, WV 26062

FMC Newell Office
1151 Washington St.
Newell, WV 26050

FMC Wintersville Office
200 Luray Dr.
Wintersville, OH 43953

304-797-7733
www.changeinc.org

Patient Name___________________________ Date of Birth_______________ Date________________

At CHANGE, Inc. much of our funding comes from government grants, so we must be able to provide estimated income information from all of the patients whom we serve. We will be asking you to provide this on a yearly basis. Please fill out this form and return it to the front desk today.

Circle the correct box with your family size (number of people you claim on income tax) and your yearly income from all sources.

YEARLY INCOME

FAMILY SIZE	**1**	0- $12,000	$13,000-$16,000	$17,000-$19,000	$20,000-$22,000	$23,000-$26,000	Greater than $26,000
	2	0-$17,000	$18,000-$21,000	$22,000-$25,000	$26,000-$29,000	$30,000-$33,000	Greater than $33,000
	3	0-$21,000	$22,000-$27,000	$28,000-$32,000	$33,000-$38,000	$39,000-$44,000	Greater than $44,000
	4	0-$26,000	$27,000-$33,000	$34,000-$39,000	$40,000-$46,000	$47,000-$53,000	Greater than $53,000
	5	0- $31,000	$32,000-$38,000	$39,000-$45,000	$46,000-$54,000	$55,000-$62,000	Greater than $62,000
	6	0-$35,000	$36,000-$44,000	$45,000-$53,000	$54,000-62,000	$63,000-$71,000	Greater than $71,000
	7	0-$40,000	$41,000-$50,000	$51,000-$60,000	$61,000-$70,000	$71,000-$80,000	Greater than $80,000
	8	0-$44,000	$45,000-$55,000	$56,000-$66,000	$67,000-$78,000	$79,000-$89,000	Greater than $89,000
	*****	Add $4,540 per member	+5,675 per member	+ $6,810 per member	+7,945 per member	+9,080 per member	

Please know that this information will be kept confidential! Thank you!