DEPARTMENT OF HEALTH AND HUMAN SERVICES

School Based Health and Wellness Centers

Health services are available to ALL children Enrolled at School Based Health and Wellness Centers!

Montgomery County Department of Health and Human Services' School Based Health and Wellness Centers (SBHWCs) provide health services, including preventive health care and sick care, to enrolled students *right in the school building*. Many students are able to be treated and return to class rather than being sent home! In most cases, parents do not have to leave work for their children to receive health services!

Services include:

- annual physical examinations
- sports physicals
- diagnosis and treatment of illness and injury
- immunizations
- medications dispensed at the sites
- laboratory work

Annual physical examinations keep children well and in school, and are recommended by the American Academy of Pediatrics.

New enrollees must complete and submit an enrollment packet. To obtain an enrollment packet, please contact the SBHWC located at your child's school.

Current enrollees should update their information on file, as needed.

Students and their families will not receive a bill for health services provided in the SBHWC.

All enrolled children will be seen regardless of their insurance status.

If your child has health care coverage that participates with Montgomery County, the insurer may be billed for services provided to your child. If your child is not insured please indicate that on your enrollment form and you will be contacted by a School Based Health and Wellness Center staff member who will assist you to apply for the Maryland Children's Health Program (HealthChoice) or the Care for Kids program.

If you have any questions, please contact the School Based Health and Wellness Center at your school.

August 2016

SBHWC Location: **Student ID #:**

Student's Name______________________ **Home School**______________ **Grade**_____

Date of Birth__________ **Social Security #** ___-__-____ **Gender** ___ **Race/Ethnicity**__________

Address ______________________________ **Home Phone**______________

City ______________ **State** _______ **Zip Code**__________ **Student Phone**__________

Country of Birth ______________ **Primary Language spoken at home** ______________

Student's Primary Health Care Provider______________________ **Phone**__________

Parent/Guardian ______________ **Date of Birth**__________ **Phone #**______________

Other Emergency Contact______________ **Contact's Phone #** ______________

Contact's Relationship to Child__________

I give permission for my child, ______________________________, to enroll in the School Based Health/Wellness Center (SBHWC). I consent to his/her receiving services which may include complete physical examinations, immunizations, treatment for chronic and acute health problems, health screenings, limited laboratory and diagnostic tests, administration/prescribing of medications, health education, case management and /or referrals to mental health and social services. I give permission for SBHWC health and mental health professionals and School Health Services staff to share information or records as needed to provide appropriate services to my child through the SBHWC and support my child's success in school.

I understand:

- The parent/guardian may or may not be present at the time services are provided, but will be notified by phone or in writing when a child receives services in the School Based Health/Wellness Center (SBHWC).
- All SBHWC records are confidential and only the SBHWC staff and providers will have access to a child's SBHWC records and information, unless the parent/guardian gives written consent, or the minor patient gives written consent, in the event the minor is receiving treatment for which the minor has the authority to consent.
- At this time, Maryland law does not require parental consent or notification for the following services provided by the SBHWC: treatment or advice about drug abuse, alcoholism, sexually transmitted infections, pregnancy or contraception to minors under 18 years of age, and mental health services to minors age 16 years or older.
- Services at the SBHWC will be provided by staff employed by or contractors with Montgomery County Department of Health and Human Services.
- If my child has health insurance through an insurance company that participates with Montgomery County, the insurer will be billed for services given in the SBHWC and the insurer may be provided required information about the child's health status or other information necessary to process insurance claims.
- If my child does not have health insurance, I will indicate on my enrollment form and I will be contacted by SBHWC staff to assist in applying for Maryland Children's Health Program (HealthChoice) or Care for Kids coverage.
- I am authorizing any payment of medical benefits for services rendered in the SBHWC to be directed to Montgomery County.
- **All enrolled children will be seen regardless of their insurance status and I will not receive a bill for services provided in the SBHWC.**

I understand the description of services and policies of the SBHWC as stated above and give permission for my child to enroll and receive services in the SBHWC. I understand that this permission can be withdrawn at any time by submitting notice in writing.

Signature of Parent/Legal Guardian______________________________ **Date**__________

Print Name ______________________ **Relationship to Student**______________

Date Form Completed ______________ SBHWC Location ______________

Montgomery County Department of Health and Human Services
School Based Health and Wellness Center

Health Insurance Information

Student's Name ______________ ______________ ______________
(last) (first) (middle)

School ______________ Date of Birth ______________

Name of Child's Doctor ______________ Doctor's Phone Number ______________

Date of Last Physical Exam ______________

Please complete the information below. Please provide a copy of your insurance card. Your insurance company may be billed.

Parent/Guardian Name: ______________ **Date of Birth** ______________

Parent/Guardian Name: ______________ **Date of Birth** ______________

Number of Family Members _____ **Family Income** _________ **weekly monthly yearly (please circle)**

Does your child have health coverage? _______ Yes _______ No

*If Yes, please check and complete **one** of the following:*

☐ My Child is enrolled in the Care For Kids Program PULS # ______________

☐ My Child has Medical Assistance (HealthChoice) *Complete below and attach a copy of HealthChoice card, if available*

Child's Medical Assistance Number __ __ __ __ __ __ __ __ __ __ __

Child's Managed Care Organization ______________
(*If you have not selected an MCO, write "none"*)

☐ My Child has private health insurance *Complete below and attach a copy of health insurance card, if available*

Name of Policy Holder ______________

Relationship to Child ______________

Social Security or ID Number of Policy Holder ______________

Policy Holder's Place of Employment ______________

Name of Insurance Company ______________

Insurance Billing Address ______________

____

All children will be seen regardless of their insurance status and will not receive a bill for services provided at the SBHWCs

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE

SCHOOL BASED HEALTH and WELLNESS CENTER

Consent to Administer Over the Counter Medications to Enrolled Students

The medications listed below are stocked at the School Based Health and Wellness Centers. If your child is **enrolled** for services, he/she may be given one of these medications, if in the judgment of the school nurse or nurse practitioner they might be helpful. You will be notified by telephone or by note, if and when your child is given of these medications.

To give your permission for your child to take any of these medications, please check **YES** below. If you do not want your child to receive one or more of these medications, check **NO.**

ASPIRIN SUBSTITUTE (acetaminophen {Tylenol}) ____YES ____NO
-For fever greater than 100.4° and/or discomfort/pain.

ANTIHISTAMINE (Loratidine {Claritin}) ____YES ____NO
-for allergic reaction and/or nasal congestion.

ANTIHISTAMINE (diphenhydramine hydrochloride {Benadryl}) ____YES ____NO
-for allergic reaction and/or nasal congestion.

Child's Name________________________ **DOB**___/___/___ **Grade**____

Parent/Guardian Signature_______________________ **Date**___/___/___

SBHWC 308-1A-EN

08/15

SCHOOL BASED HEALTH AND WELLNESS CENTER
STUDENT HEALTH HISTORY

Patient Name:		Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: ____________________

Illnesses during pregnancy? No ☐ Yes ☐

Medications during pregnancy? No ☐ Yes ☐

Alcohol/Drug Abuse? No ☐ Yes ☐

Problems at birth? No ☐ Yes ☐

Describe: ____________________

Type of delivery? ☐ Vaginal ☐ C-section

Birth Weight____________Discharge Weight______

Did baby receive Hepatitis B vaccine? No ☐ Yes ☐

Date of Hepatitis B immunization:____________

Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?____________________

____

How many?______

☐ Rent? ☐ Own? ☐ Shelter?

Who cares for child?____________________

Date of Birth? Mother____________________

Father____________________

Are parents working? Mother No ☐ Yes ☐

Father No ☐ Yes ☐

Foster Care? __________Dates:____________

Other Languages?____________________

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

		Who?
Allergies (List) ____________	No ☐	Yes ☐_____
Asthma	No ☐	Yes ☐_____
TB/Lung Disease	No ☐	Yes ☐_____
HIV/AIDS	No ☐	Yes ☐_____
Suicide Attempts	No ☐	Yes ☐_____
Heart Disease	No ☐	Yes ☐_____
High Blood Pressure/Stroke	No ☐	Yes ☐_____
High Cholesterol	No ☐	Yes ☐_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐_____
Diabetes	No ☐	Yes ☐_____
Seizures	No ☐	Yes ☐_____
Mental Illness	No ☐	Yes ☐_____
Cancer	No ☐	Yes ☐_____
Birth Defects	No ☐	Yes ☐_____
Hearing Loss	No ☐	Yes ☐_____
Speech Problems	No ☐	Yes ☐_____
Kidney Disease	No ☐	Yes ☐_____
Alcohol/Drug Abuse	No ☐	Yes ☐_____
Hepatitis/Liver Disease		
Thyroid Disease	No ☐	Yes ☐_____
Learning Problems/Attention	No ☐	Yes ☐_____
Deficit Disorder	No ☐	Yes ☐_____
Family Violence	No ☐	Yes ☐_____

Other: ____________________

MEDICAL HISTORY

Has your child ever had:

Allergies (List) ____________	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: ____________	No ☐	Yes ☐

Current Medication(s): (*List*) ____________________

Reviewed by:	Date of Review:

Montgomery County Department of Health and Human Services
Notice of Privacy Practices Summary and Signature Page

What is the Notice of Privacy Practices?
We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

How will we share your information?
Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services. Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice.*

Contact Information:
If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 3050. Additional contact information is provided at the end of the *Notice.*

Acknowledgement of receipt of the complete *Notice*:

______________________________ ______________
Client or Authorized Representative (Sign your name) Date

____
Print your name

______________________ ______________________
Signature of DHHS representative Signature of interpreter/translator if applicable

If unable to get acknowledgement, specify why: ______________________

DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH AND OTHER PERSONAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Our Services and Information We Collect

The Montgomery County Department of Health and Human Services (DHHS) is a large, multi-service agency that provides health, mental health, substance abuse, child welfare, income support and other social services. To provide you with services, DHHS staff will ask you for personal information that they will keep in your records. This information may include:

- Information that identifies you, such as your name, address, telephone number, date of birth and social security number.
- Financial information, which includes information about your income, your bank accounts or other assets, and any insurance coverage that you have.
- Protected health information, which includes any information that tells us about your past, present or future health or mental health treatment.
- Information about benefits or services that you are receiving or have received.

Our Responsibilities

Federal and State laws protect the privacy of your health and other personal information and we will follow all of those laws. We will take reasonable steps to keep your information safe, and will use (share within DHHS) and disclose (share with persons outside of DHHS) your information only as necessary to do our jobs and as permitted or required by law. We are required to let you know if a breach occurs that may have compromised the privacy or security of your health information.
If we have a need to use or disclose your information for any reason other than those listed below, we will ask you for your written permission. You have a right to cancel any written permissions you have given to us. If you cancel your permission, the cancellation will not apply to uses and disclosures that we have already made based on your permission.

We are required by law to provide you with this notice and to follow it. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on the DHHS website at www.montgomerycountymd.gov

How We May Use and Disclose Your Information

- **For Treatment and Services:**
  DHHS staff who work with you may use your health and other personal information as necessary to provide you with coordinated treatment and services. DHHS has implemented an integrated case management system and an electronic health record to store your health and other personal information. We may gather information about you from other health care providers you have

seen, healthcare facilities that have run tests on you, your health insurance plan and, sometimes, even family members or close friends that help take care of you. Some or all of your medical information may be created and/or stored in an electronic format.
Examples:

- o If you are receiving health care from one of our clinics and want to apply for other services such as housing assistance or income supports, your case worker can help you access those services by making referrals and sharing eligibility information.

- o If you are receiving more than one DHHS service, your case workers may communicate with one another to develop a coordinated service plan with you when appropriate.

When permissible for valid purposes (e.g. providing treatment or billing for services) your health care providers may access your medical information electronically. Other healthcare providers outside DHHS caring for you may also receive access to your electronic records.

We will share your information with persons outside of our DHHS agency for treatment or services only with your written permission or as allowed by federal or State law. For example, federal and State laws permit our DHHS staff that provide you with health care to share your health information with outside health care providers who are also treating you.

<u>If you receive behavioral health services from us</u>:

- o Your mental health records may be shared to provide you with treatment or services without your authorization, but we will only share information that is relevant to your treatment or service plan.
- o We maintain one electronic health record for your health and behavioral health information so that our health care providers can make informed treatment decisions and coordinate your health care.
- o Most sharing of psychotherapy notes will be done only with your written authorization. Psychotherapy notes are defined by law as notes created by a mental health professional that are kept separate from your health record. In general, our staff include all of their notes in your health record and do not maintain separate psychotherapy notes.
- o We will not share your alcohol or substance abuse program records unless:
  - You have given us your written permission;
  - The disclosure is allowed by court order;
  - The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation;
  - We are sharing with someone who is providing services to you or our program, and we have an agreement in place to protect the information. *We have these agreements in place to allow your substance abuse program records to be shared with your DHHS health and behavioral health care providers.*
- o We will not share your information from our Abused Persons, Victim's Assistance and Sexual Assault Programs without your written permission except as permitted or required by law. These programs are restricted within our electronic systems.

Some of our programs maintain records that are considered "education records" under the Family Education Rights and Privacy Act of 1974 ("FERPA"). We will not share information about you from these records with other service providers without your written permission unless it is necessary to address an emergency.

DHHS has chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a regional health information exchange (HIE). As permitted by law, your health

information may be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt Out form to CRISP by mail, fax or through their website at www.crisphealth.org. If you opt out of participation in CRISP, your health care providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail or other electronic communications. Legally mandated public health reporting, such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

Health Information. We may use or disclose your health information to provide information to you about treatment alternatives, other services or other health related benefits and services that may be of benefit to you.

DHHS Directory. Unless you object, we may use your health information, such as your name and general demographic information for our directory. The information contained in our directory will not be disclosed to individuals outside of our health and human services environment with your authorization.

- **For payment:** We may use or disclose health and other personal information about you as necessary to obtain payment for health and mental health services received. For example, we may use your information to bill Medicaid or Medicare for treatment you received.

- **For Health Care/Business Operations:** We may use or disclose your health and other personal information to manage our programs or activities. For example, DHHS staff or outside auditors may look at your case record to review the quality of services you received through our department.

- **For Appointments or Notifications:** We may need to contact you or your representative, to schedule or remind you of an appointment, to ask you to complete paperwork, to inform you about other related benefits or services that you may be interested in, or to reach you in an emergency.

- **To our Business Associates:** We have agreements with persons outside of DHHS that perform services on our behalf, or provide us with administrative and support services, such as financial or legal services, data analysis, and accreditation and quality assurance reviews. These persons are called business associates. We may disclose your information to business associates so that they can perform these services for us. However, we require our business associates to keep your information safeguarded.

- **To your Family, Friends and Others Involved in Your Care:** We may disclose your health information to your family or others who are involved in your medical care. For example, we may discuss your medical condition with your adult daughter or son who is arranging for your care at home. If you do not want us to share this information with your family, you can ask that we not do so. We will not share information about your mental health or substance abuse history or care with your family unless you give us written permission.

- **For Government Programs:** We may disclose health and other personal information about you to determine if you are eligible for other government benefits or programs such as Social Security benefits.

- **For Public Health Activities:** We may use or disclose health information about you for public health activities. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of this disease.

- **For Health Oversight Activities:** We may disclose your information as required by law to other agencies who oversee our programs for oversight activities such as audits, inspections, investigations, and licensure.

- **For Abuse and Neglect Reports and Investigations:** We are required by law to report any cases of suspected abuse or neglect of children or vulnerable adults, including adults abused as children. Health and mental health providers are required by law to share information with adult and child protective services if the health/mental health care provider believes the information will contribute to the protective service investigation, assessment of risk, or service/safety plan.

- **To Avoid Harm:** DHHS may disclose health and other personal information about you to law enforcement under certain conditions. For example, if you harm a member of our staff or another client, if you damage our property or if our professional staff believes that you are likely to cause serious harm to others or yourself, we will contact law enforcement. DHHS may also disclose your health and other personal information in case of a threat to the public, such as a terrorist attack or emergency disaster.

- **To Coroners, Funeral Directors, Medical Examiners and for Organ Donation:** DHHS may disclose health information relating to death to coroners, medical examiners and funeral directors and also to authorized organizations relating to organ, eye or tissue donations or transplants.

- **For Research Purposes:** We may use or disclose your health information for medical research purposes under certain circumstances. In some cases, your written permission will be needed. Research studies and reports will not identify people by name.

- **For Court proceedings:** We may be required by law or court order to provide information about you to the court. We may also share health information about you for workers' compensation claims.

- **As Required by Law:** If a law or regulation requires that we disclose your health or other personal information, we must do so.

- **Fundraising:** We generally do not engage in fundraising with our clients, but if we contact you for fundraising efforts, you can tell us not to contact you again.

- **Health Information Availability After Death.** DHHS may use or disclose your health information without your authorization fifty (50) years after your death. You have the right to restrict those disclosures.

Your Rights Regarding your Information

You have the right to:

- Obtain a copy of this notice. This notice is available in alternative format upon request.
- Ask us to contact you at a different location or to contact you by a different method than we routinely use. For example, you may ask that we contact you by phone or mail at work instead of at home.

- See, review and receive a copy of information we maintain about you. *You must make this request in writing* and you may be charged a fee to pay for the cost of copying your record. There are certain situations when we may not give you the right to review or obtain a copy of your records. If this happens, we will explain why. If we maintain your health information in an electronic record, you can also ask for your information in an electronic format.
- Ask us to correct information about you that you think is incorrect or incomplete. *You must do this in writing.* In some situations, we are not required to make the change. If we do not agree to make the change, we will explain why.
- Ask for a list (accounting) of the times we have disclosed your health information for six years prior to the date you ask. This listing will not include disclosures made for treatment, payment or health care operations purposes, or disclosures you have permitted us to make. *You must make this request in writing.*
- Request that we not share health information with a family member or others involved in your care.
- Request that we not share your information for a treatment/service, payment or health care operations purpose. *These requests must be made in writing.* We are not required to agree to these requests, but if we do, we must comply with the agreement, unless we need to disclose the information for your emergency treatment. If we cannot agree to your request, we will explain why.
- If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to comply with your request unless a law requires us to share that information.
- Require that we obtain your written permission if we want to sell your information or share your information for marketing purposes.
- Receive a notification from us if there is ever a breach of your information.
- File a complaint or report a problem if you feel we have violated your rights. We will not take any action against you for filing a complaint. To file a complaint or report a problem contact our Privacy Officer at the following address:

  Privacy Officer
  Montgomery County Department of Health and Human Services
  401 Hungerford Drive
  Rockville, MD 20850
  240-777-3819 (Voice) 240-777-1398 (TTY)

  If your complaint relates to your *health* information, you may also contact the U.S. Department of Health and Human Services, Office for Civil Rights by calling 1-877- 696- 6775.

How to Make a Request

If you have questions about our privacy practices or want to make a request for any of the above, contact the staff person who is working with you, or our Privacy Official at the address listed above. We ask that you use the *DHHS Client Request Form* for requests that must be made in writing. You can obtain the form from any DHHS office or by contacting our Privacy Officer.

Effective Date: This notice is effective on January 23, 2017.