Carthage Area Hospital's School Based Health Center

Dear Parents/Guardians,

Carthage Area Hospital and your school district look forward to providing health care to the students in your community. This health care delivery program is called a School-Based Health Center (SBHC). Your SBHC can provide primary, preventive health care, nutrition, and mental health services to students enrolled in the program in a quick, easy, and cost-effective manner with no out of pocket cost to you.

Staffing & Availability. The School-Based Health Center (SBHC) is equipped with a team comprising a Nurse (LPN), a Physician's Assistant (PA) or Nurse Practitioner (NP), Mental Health Therapist(s), a Nutrition Specialist, and a Clinic Manager. Each medical provider and mental health professional operates under the supervision of an SBHC Medical Director (Dr. Gianfagna; Carthage Family Health Center, 117 N. Mechanic Street Carthage NY 13619; reachable at 315.493.4187) and a Behavioral Health Supervisor.
Services are offered during the academic day, coinciding with regular school hours. Additional hours may be introduced during the summer, typically towards the end of the academic year

Services. Our medical care team provides services that include primary and preventive health care, diagnosis and treatment of medical conditions, management of chronic conditions, sick visits (i.e. ear infections & strep throat), nutrition counseling services, and referrals to specialty care when necessary. We also provide immunizations, physicals (annual, school, sport or camp) and allergy injections. Our mental health team provides assessment, diagnosis and counseling services. Lastly, limited dental services are offered at select locations.

Cost. You will **NOT** be responsible for any out-of-pocket costs for a clinic visit at the SBHC. We bill all insurance companies and accept what the insurance company pays as full payment. You may receive an explanation of benefits (EOB) from your insurance, but you will not receive a bill. Please **note**, depending on your insurance coverage, you ***MAY*** need to pay for any treatment or testing that is completed outside of the SBHC (i.e. blood work, lab cultures, x-rays, etc.) and/or consults with specialists and other specialty care. If you have any questions in regards to your EOB, please call the Carthage Area Hospital Billing Department at 315-519-5865.

PCP Options. A student can be enrolled in the SBHC *and* keep their regular primary care physician (PCP). If a student doesn't have a designated doctor, you can enroll your child and use the SBHC as your child's primary care provider.

Access. When the SBHC is closed, you may seek care at other Carthage Area Hospital entities:

- Carthage Walk-In Clinic. 22075 Constitution Drive, Carthage. (315) 519-5830.
- CAH Pediatrics. 117 N. Mechanic Street, Carthage. (315) 493-4187.
- Philadelphia Medical Center. 32787 US-11, Philadelphia, NY 13673
- Carthage Area Hospital Emergency Department. 1001 West Street, Carthage. (315) 493-1000.

In order for the SBHC to provide optimal care it is important that we have current information on your child's health and health insurance coverage. We kindly ask that you complete the attached forms:

_____ Page 3, Student Enrollment Form
_____ Pages 4-5, Consent Form
_____ Page 6, Annual Influenza Vaccine Consent Form

Lastly, please remove this cover letter to keep for future reference. We look forward to serving you!
Sincerely,
Your School Based Health Center Staff

Carthage Area Hospital's School Based Health Clinic - Patient's Bill of Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
6. Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7. Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care - A Guide for Patients and Families."
11. Refuse treatment and be told what effect this may have on your health.
12. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13. Privacy while in the hospital and confidentiality of all information and records regarding your care.
14. Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
15. Review your medical record without charge and obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. Receive an itemized bill and explanation of all charges.
17. View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.
18. Challenge an unexpected bill through the Independent Dispute Resolution process.
19. Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
20. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
21. Make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as a health care proxy, will, donor card, or other signed paper). The health care proxy is available from the hospital.

Public Health Law (PHL) 2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

Carthage Area Hospital's School Based Health Clinic - Parent's Bill of Rights

As a parent, legal guardian or person with decision-making authority for a pediatric patient receiving care in this hospital, you have the right, consistent with the law, to the following:

1. To inform the hospital of the name of your child's primary care provider, if known, and have this information documented in your child's medical record.
2. To be assured our hospital will only admit pediatric patients to the extent consistent with our hospital's ability to provide qualified staff, space and size appropriate equipment necessary for the unique needs of pediatric patients.
3. To allow at least one parent or guardian to remain with your child at all times, to the extent possible given your child's health and safety needs.
4. That all test results completed during your child's admission or emergency room visit be reviewed by a physician, physician assistant, or nurse practitioner who is familiar with your child's presenting condition.
5. For your child not to be discharged from our hospital or emergency room until any tests that could reasonably be expected to yield critical value results are reviewed by a physician, physician assistant, and/or nurse practitioner and communicated to you or other decision makers, and your child, if appropriate. Critical value results are results that suggest a life-threatening or otherwise significant condition that requires immediate medical attention.
6. For your child not to be discharged from our hospital or emergency room until you or your child, if appropriate, receives a written discharge plan, which will also be verbally communicated to you and your child or other medical decision makers. The written discharge plan will specifically identify any critical results of laboratory or other diagnostic tests ordered during your child's stay and will identify any other tests that have not yet been concluded.
7. To be provided critical value results and the discharge plan for your child in a manner that reasonably ensures that you, your child (if appropriate), or other medical decision makers understand the health information provided in order to make appropriate health decisions.
8. For your child's primary care provider, if known, to be provided all laboratory results of this hospitalization or emergency room visit.
9. To request information about the diagnosis or possible diagnoses that were considered during this episode of care and complications that could develop as well as information about any contact that was made with your child's primary care provider.
10. To be provided, upon discharge of your child from the hospital or emergency department, with a phone number that you can call for advice in the event that complications or questions arise concerning your child's condition.

Public Health Law (PHL) 2803(i) (g) Patients' Rights 10NYCRR, Section 405.7

SBHC Student Enrollment Form

Student Information:

Patient Name (First, MI, Last):_____ **DOB**: _____ **SS#**:_____ **Grade**: ____

Street Address: _____ **City**: _____ **Zip code**: _____ **County**: _____

Gender at Birth: ☐ Male ☐ Female **Gender Identity**: _____ **Mother's Maiden Name**:_____

Student's phone # _____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Decline to Answer ☐ Other: _____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to answer **Religion**: _____

Primary Healthcare Information:

☐ My child does not have a Primary Care Provider and would like the School Based Health Center to be the Primary Care.

☐ My child has a Primary Care Provider, but would like to access care from the School Based Health Center.

PCP Name: _____ **Address**: _____ **Phone**: _____

Dentist Name: _____ **Address**: _____ **Phone**: _____

Date of Dental Last Exam:_____

Pharmacy: _____ **Phone**: _____

Parent/Guardian Information:(First, MI, Last):

Name: First: Last: MI:	**Name: First: Last: MI:**
Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian- (Please provide a copy of court order) ☐ Other:	**Relationship to Student**: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian- (Please provide a copy of court order) ☐ Other:
Date of Birth:	**Date of Birth**:
Mailing Address:	**Mailing Address**:
Best Phone Number to Reach You: _____ ☐Cell ☐ Home **Okay to leave a message**: ☐ Yes ☐ No	**Best Phone Number to Reach You**: _____ ☐Cell ☐ Home **Okay to leave a message**: ☐ Yes ☐ No
Email:	**Email:**
Employer:	**Employer:**
Work Phone:	**Work Phone:**

Who Does the Student Live With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Other: _____

Who Will Make Healthcare Decisions for This Student: ☐ Father ☐ Mother ☐ Guardian ☐ Other: _____

Emergency Contact Name: _____ **Phone**: _____ **Relationship**: _____

Is This Person Able to Make Medical Decisions if Unable to Contact Parent/Guardian: ☐ Yes ☐ No

Primary Medical Insurance: ***Please Attach Copy of Insurance Card(s)***

☐ Student has insurance

☐ Student has NO Insurance ☐ **I'm interested in speaking with a health insurance enrollment specialist.**

Primary Insurance Company Name:	**Secondary Insurance Company Name:**
Medical Policy/ID #:	**Medical Policy/ID #:**
Billing Address of Insurance Co:	**Billing Address of Insurance Co:**
Policy Holder's Name and Date of Birth:	**Policy Holder's Name and Date of Birth:**
Policy Holder's Social Security #:	**Policy Holder's Social Security #:**

Responsible Person Information: Who Is In Charge of Students Insurance/Billing Information?

☐ Father ☐ Mother ☐ Step Parent ☐ Guardian ☐ Other: _____

PARENT/GUARDIAN NAME (PRINTED): _____ **RELATIONSHIP:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Student Name: _____ Date of Birth: _____

Student Health Information:

Is your student taking any medications: ☐ Yes ☐ No
If yes, please list with dosage: _____
Allergies: ☐ Yes ☐ No
If yes, please list with type of reaction:
_____
Date of Last Physical Exam: _____
(Please attach copy of Physical and/or complete *Authorization for Release of Health Information* so we are able to obtain a copy)

Has your student had any history of/or conditions related to any of the following:

☐ ADHD ☐ Asthma ☐ Autism ☐ Bleeding Disorder ☐ Cancer ☐ Cardiac Issues ☐ Diabetes
☐ Dental Problems ☐ Eczema ☐ Eye Problems ☐ Bone Fractures ☐ Kidney/Urinary Issues
☐ Mental Health Condition(s):_____ ☐ Migraines ☐ Seizures ☐ Thyroid Issues
☐ Other: _____

Serious Accidents: ☐ Yes ☐ No If yes, please list: _____
Operations/Surgeries: ☐Yes ☐ No If yes, please list: _____
Hospital Visits (Overnight): ☐ Yes ☐ No If yes, please list: _____

Is there anything you feel we should know or any concerns you have about your child that you would like us to be aware of: ☐ Yes ☐ No If yes, please Explain: _____

Family History:

Check any of the following conditions a relative has had, please include both mothers and fathers side of family:

	Mom	Dad	Sister Brother	Aunt Uncle	Grand-Parents		Mom	Dad	Sister Brother	Aunt Uncle	Grand-Parents
Asthma						Kidney Disease					
Cancer						Stroke					
Diabetes						History Unknown					
Heart Disease						**Mental Health Disorder					
High Blood Pressure						Other:					
High Cholesterol											

** Mental Health Disorder: Please Specify: _____

PARENT/GUARDIAN NAME (PRINTED): _____ RELATIONSHIP: _____
PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Carthage Area Hospital's School Based Health Center (SBHC) Consent Form

Student's Name (Printed): _____ DOB: _____

Consent to Treatment: I give consent for my child to receive all health care services deemed necessary and provided by the staff at the SBHC. Providers employed by Carthage Area Hospital staff the SBHC program which is licensed by the New York State Department of Health. Services provided by the SBHC include, but not limited to:

Medical:

- Screenings for vision, hearing, asthma, obesity, scoliosis, tuberculosis and other medical conditions, first aid, and required and recommended immunizations by the Centers for Disease Control and Prevention (CDC).
- Comprehensive physical examination including those for school, sports, working papers, etc.
- Medical care and treatment, including diagnosis of acute and chronic illness and disease.
- Mental health screenings and referrals for evaluations.
- Medically prescribed laboratory tests and medications.
- Reproductive health care services, including abstinence counseling, contraception, testing for pregnancy, sexually transmitted disease (STD) screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate.
- Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, STD, and HIV, as age appropriate.
- Annual health assessment.
- Referrals for service provided at the SBHC *and* for services not provided at the SBHC.

Nutrition:

- Initial assessment of need for nutrition services and subsequent follow up appointments as appropriate. Following the initial assessment, I understand I will be contacted by the dietician to discuss the treatment plan.
- Nutrition counseling and goal setting. I understand that I may be asked to attend an appointment at the SBHC to further discuss goals and interventions.

Mental Health:

- Comprehensive assessment. Following the comprehensive assessment, I understand I will be contacted by the therapist to discuss the assessment, diagnosis and treatment plan. I understand I may be asked to attend a meeting with the SBHC mental health therapist to further discuss possible treatment options.
- Therapy sessions. I understand I may be asked to attend or participate in my child's treatment. I give permission for the mental health therapist to discuss pertinent information with the school, clinical supervisor, interdisciplinary team, and if necessary with Carthage Behavioral Health for the purpose of a referral for medication therapy. This may include immediate crisis intervention.
- Mental Health treatment will be provided by licensed mental health providers in accordance with current NYS Mental Hygiene Laws.

Access to Medical Records: I give consent for the SBHC to have access to my child's health records, to include demographics, insurance information, social security number and schedules, maintained by their school and primary healthcare. I understand that effort will be made to contact me prior to treatment that requires parental consent according to New York State law. However, I understand that there might be times when clinic personnel are unable to contact me and give consent to provide treatment as they deem necessary (including but not limited to: all tests, labs, medications, wounds and sick visits). **I understand that my child is required, by New York State Regulation, to have a physical on file with the SBHC. If my child has had a physical by their PCP, I agree to provide the clinic with a copy of it. In the event that I do not furnish/present a physical or a signed note stating that my child has an appointment to get his/her physical by his/her PCP, to the SBHC by October 1st of each new school year, I understand and give permission for the clinic to provide my child with their annual physical.** The staff of the SBHC considers parental consent to be very important. The staff will encourage every student to involve their parent(s)/guardian(s) in all SBHC treatment decisions.

Authorization & Assignment of insurance benefits: I hereby authorize Carthage Area Hospital or any providers who have attended to my child, to release to governmental agencies mandated by law, insurance carrier(s) designated or their representatives all information needed to substantiate payment for such hospitalizations and medical care and to permit representation there to examine and make copies of all records relating to such care and treatment. I certify that the insurance information given by me is, to the best of my knowledge, correct. If my child's health insurance changes at any time I agree to provide the SBHC with updated information. I hereby authorize and assign payment to Carthage Area Hospital of all benefits due and payable under the terms of my policies and/or contracts. I assign payment to the physicians of all medical benefits available for these professional services.

Consent to Access External Prescription History: I authorize Carthage Area Hospital Providers to access my child's electronic medication history from external sources without limitation or exclusion as necessary for his/her care and treatment.

Photo Consent: All enrollees have an electronic medical record which is shared with the other outpatient clinics affiliated with Carthage Area Hospital only including, but not limited to: pediatrics and family practice (backup clinic used when school/school clinic is closed). Part of this electronic medical record includes a photograph of each patient to confirm identity and prevent any safety or Health Insurance Portability and Accountability Act (HIPAA) concerns. This photograph will only be used as an identifier on your child's electronic medical record and will not be used for any other purpose.

Bill of Rights: I have received, had the opportunity to ask questions and understand the patient's bill of rights for the patient whose name appears above. I have received the clinic information cover page, hours of operations, parent's bill of rights, SBHC enrollment form and consent and authorization to disclose information.

Grievances: I understand all students and the families of all enrolled students have the right to voice grievances and to recommend changes in policy to staff members or the Advisory Committee without fear of reprisal. Grievances concerning the quality of care, the facility, the services provided, the hours of operation, a particular staff member, etc., should be directed to the Clinic Manager. The grievance will be dealt with by the management team member responsible for the area of concern and resolved as soon as possible. A response will be given to the student as soon as possible. If the management team does not resolve a student grievance, the chairperson of the Advisory Committee will present it to the Board of Directors for their consideration. The Board of Directors will then respond to the grievance. If the student is not satisfied with the response, they have the right to contact the New York State Department of Health Regional Office, 217 South Salina Street, Syracuse, NY 13202, or call the NYS Department of Health at (315) 477-8135.

PCP Involvement: If my child has another Primary Care Provider (PCP), I will indicate this on the enrollment form. I would like the SBHC to work with my child's PCP to keep my child healthy. I give permission to SBHC personnel to release medical records of all treatable visits to the provider listed on the enrollment form as requested by my child's PCP. If my child does not have a regular PCP, I will indicate this on the enrollment form. I would like the SBHC to provide care as necessary to keep my child healthy. I would like the SBHC to work with my child's school nurse to keep my child healthy. I give permission to SBHC personnel to release a copy of my student's annual physical, immunization record and health history to the school nurse to ensure the health and safety of my child as needed. I understand that if my child needs a referral for Mental Health Services or Nutritional Services, a referral will be made. I give permission for the SBHC to release medical records to the appropriate staff.

It is the policy of the Hospital, in conjunction with the Division of Operations (Region 2) of the Bureau of Health Workforce to ensure all patients (outpatient and inpatient) receive treatment without discrimination as to race, color, national origin/citizenship status, age, disability, religion/creed, marital/familial status, sex, sexual orientation, gender identity, military status, ability to pay or source of payment.

Parent/Guardian Name (printed): _____ Relationship: _____

Parent/Guardian Signature: _____ Date:_____

Influenza Immunization Consent Form

This is optional – if you'd like your child to receive the Influenza vaccine at the SBHC, please complete

Please review the following categories to determine eligibility for vaccinations under the Vaccines for Children (VFC) Program and check the one that applies to your child:

__ Medicaid Enrolled __Uninsured __Native American __Child Health Plus B enrolled

__Underinsured (insurance does not cover the cost of immunization) __None of the above

Section 1: Information about the child who is to receive the vaccine

Student's Last Name: _____ Student's First Name: _____ MI: _____
Date of Birth: _____ Age: _____ Gender at birth: M F
Parent/Guardian Last Name: _____ Parent/Guardian First Name: _____ MI: _____
Student's Full Address: _____
Parent/Guardian Daytime Phone Number: _____
Student's Primary Care Provider (last, first): _____

Section 2: Screening for vaccine eligibility

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "no" to all of the following questions, your child can probably get the vaccine. If you answer "yes" to one or more of the following questions, we may contact you to discuss your options. Please circle yes or no for each of the following five questions.

1.)	Was your child vaccinated with the seasonal influenza vaccine AFTER July 1st of **(2024)**?	Yes	No
2.)	Does your child have a serious allergy to eggs?	Yes	No
3.)	Does your child have any other serious allergies? If so please list below.	Yes	No
4.)	Has your child ever had a serious reaction to a previous dose of flu vaccine?	Yes	No
5.)	Has your child ever had Guillain-Barre Syndrome within 6 weeks after receiving a flu vaccine?	Yes	No

Allergy list: _____

Section 3: Consent

I have read or had explained to me the current Vaccine Information Statement (see attached) for the seasonal influenza vaccine and understand the risks and benefits. I give consent to the School Based Health Clinic staff for my child (named at top of form) to be vaccinated.

Parent/Guardian Name (printed): _____ Relationship: _____

Parent/Guardian Signature: _____ Date:_____

For Administrative Purposes Only

Vaccine: Influenza
Route: IM
Vaccine Manufacturer: _____
Lot Number: _____
Name and Title of Vaccine Administrator: _____
Date of Vaccination: _____
Expiration Date: _____