School-Based Health Center Enrollment

Dear Parent and Guardians,

Valley Health Care Inc. (VHC) is pleased to offer school-based health services at your child's school. VHC will be sending licensed healthcare providers to your child's school to provide on-site **medical** care. The primary goal for this school-based health center is to work in conjunction with your child's regular primary care provider (PCP) with the express goal of providing comprehensive care to your child. Some examples of the services we can provide are:

- Treatment for acute illnesses such as the flu
- Treatment for chronic illnesses such as asthma and diabetes
- Immunizations and vaccinations
- School and sports physicals
- Referrals and coordination of outside services such as x-rays, dental work, and other services not available at the school-based health center

All children enrolled in the school-based health services program are eligible to receive services regardless of insurance status. VHC accepts most insurance plans, including WV CHIP and Medicaid. Coverage and costs for services provided depends upon your insurance coverage.

If you have no insurance, please contact VHC for assistance in enrolling in an insurance plan or the VHC Care Program or for assistance with enrolling in an insurance plan through the Healthcare Marketplace. The VHC Care Program provides care to uninsured patients at a rate of 20% to 50% of the total cost.

For unscheduled acute care visits, we will attempt to notify the parents if a student needs to be seen by a provider. If the parent cannot be reached, the student will be treated and given a note to take to the parents with the findings and recommendations of the provider.

Parents are encouraged to actively participate in their child's health care. You are welcome to contact the health center any time. We hope that we can help your child have a healthy and successful school year.

If you are interested in allowing your child to receive school-based health services, please check yes on the box below and sign this form. If your child is already a patient of Valley Health Care, please indicate this by checking the box below.

If you would like assistance in completing the consent packet, please check the box on the next page. Please feel free to contact us at any time.

CONTACT INFORMATION:

Valley Health Care Inc.
P.O. Box 247
Mill Creek, WV 26280
Phone: 304-335-2050
Fax: 304-335-2050
vhcsbhc@gmail.com

VALLEY HEALTH CARE, INC.
QUALITY HEALTH CARE THAT'S CLOSE TO HOME

School-Based Health Center Enrollment

I give consent to receive services at the Valley Health Care, Inc. School-Based Health Center located within my child's school.

All healthcare information is confidential. By signing the consent form you are giving the Valley Health Care, Inc., the school nurse, and your regular doctor (if applicable) permission to communicate and share medical information regarding your medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payers for billing purposes.

Confidentiality between the student, parents, school staff, and the health center is assured.

I am the legal guardian of the below named child. I understand that a new consent must be signed by the legal guardian if guardianship changes. I also understand that if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

Patient Name: _____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

Signature of Patient (if over 18): _____

Date: _____

VALLEY HEALTH CARE, INC.
QUALITY HEALTH CARE THAT'S CLOSE TO HOME

School-Based Health Center Enrollment

Student/Patient Information		
Name:		
Name of Parent/Guardian:		
Gender: ❑ Male ❑ Female		
Date of Birth:	SSN:	Phone:
Current Address:		
City:	State:	ZIP Code:
Current Living Address if different:		
City:	State:	ZIP Code:
Ethnicity: ❑ Hispanic ❑ Non-Hispanic	Race (Please check all that apply): ❑ White ❑ Black ❑ Asian ❑ American Indian ❑ Native Hawaiian ❑ Pacific Islander ❑ Other:	
Veteran Status: ❑ Yes ❑ No		

Primary Insurance Information		
Insurance:	INS. Medicaid ID #	Group #
Insurance Phone Number:	Policy Holders Name:	
Policy Holders SS#	Employer:	DOB:
Relationship to Patient:		

Secondary Insurance Information		
Insurance:	INS. Medicaid ID #	Group #
Insurance Phone Number:	Policy Holders Name:	
Policy Holders SS#	Employer:	DOB:
Relationship to Patient:		

Emergency Contact	
Name:	
Cell Phone:	Relationship to Student:
Name:	
Cell Phone:	Relationship to Student:

School Information	
Name of School:	
Home Room:	Grade:

Valley Health Care, Inc. is a FQHC (federally qualified health center) and receives federal funding which provides services to our uninsured/underinsured population. A requirement of this funding is to ask the following questions. Should you need any assistance in answering these questions our front office staff will be glad to help you.

How many members are in your household? (A household includes a mother, father, and dependent children less than 18 years of age)

To complete the table below, please check the box next to your household size that best describes your annual household income.

Household Size	Annual Household Income			
1 →	☐Less than $11,770	☐$11,770 to $17,655	☐$17,656 to $23,540	☐Greater than $23,5
2 →	☐Less than $15,930	☐$15,930 to $23,895	☐$23,896 to $31,860	☐Greater than $31,8
3 →	☐Less than $20,090	☐$20,090 to $30,135	☐$30,136 to $40,180	☐Greater than $40,1
4 →	☐Less than $24,250	☐$24,250 to $36,375	☐$36,376 to $48,500	☐Greater than $48,5
5 →	☐Less than $28,410	☐$28,410 to $42,615	☐$42,616 to $56,820	☐Greater than $56,8
6 →	☐Less than $32,570	☐$32,570 to $48,855	☐$48,856 to $65,140	☐Greater than $65,1
7 →	☐Less than $36,730	☐$36,730 to $55,095	☐$55,096 to $73,460	☐Greater than $73,4
8 →	☐Less than $40,890	☐$40,890 to $61,335	☐$61,336 to $81,780	☐Greater than $81,7

VALLEY HEALTH CARE, INC.
QUALITY HEALTH CARE THAT'S CLOSE TO HOME

MEDICAL AUTHORIZATION AND CONSENT INFORMATION

I do herby authorize the release of any medical information necessary to process all insurance claims and payment and all insurance benefits to VALLEY HEALTH CARE, INC. on my behalf. I also agree that Valley Health Care can receive direct payment from Medicare, Medicaid, Champ US, and the above named or any private insurance company you may have for which Valley Health Care bills.

I agree to receive routine medical care from the Physicians, Nurse Practitioners, AND Physician Assistants employed by Valley Health Care. Valley Health Care may **RELEASE INFORMATION** from my medical record to these insurance companies to help in processing my insurance claim.

I understand that I have the right to be completely informed about the nature of any treatment I may receive.

I understand that I may withdraw this consent at any time by contacting, in writing, any member of the professional staff at Valley Health Care.

Patient Name: _____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian:_____

Signature or Patient (if over 18): _____

Date: _____

Questions about your child:

❑ Yes ❑ No Does your child have a Primary Care Doctor or Clinic? If Yes, please provide:

Provider Name: _____ Phone #: _____

❑ Yes ❑ No Has your child had a physical or full check up in the past year?

❑ Yes ❑ No If your child has not had a physical or full check up in the past year, would you like us to perform a Well-Child Visit for your child this school year?

❑ Yes ❑ No Does your child have any MEDICATION allergies? _____

❑ Yes ❑ No Does your child have allergies to anything else? (foods, dust mites, etc.)
If Yes, please list**:** _____

❑ Yes ❑ No Does your child take regular medications? (include vitamins and over-the-counter medications; please provide the name of the medication(s), the dosage, and the reason why the child is taking the medication)_____

_____

_____

_____

❑ Yes ❑ No Is there any other medical information regarding the student that should be noted_____

_____

_____

_____

_____

Valley Health Care has my permission to administer the following over-the-counter medications at the discretion of the medical provider.

❑ Ibuprofen ❑ Antacids ❑ Sudafed ❑ Benadryl ❑ Tylenol ❑ Cough Syrup ❑ Claritin

By signing this form I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school-based health staff if any of my child's medical history changes.

Patient Name: _____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

Signature of Patient (if over 18): _____

Date: _____