2200 W. 22nd Street
Anderson, IN 46016
Kindergarten - Delta
765.649.8472 - office
765.640.5445 - fax
www.goapa.org

101 W. 29th Street
Anderson, IN 46016
Echo - 12th Grade
765.649.8742 - office
765.640.2550 - fax
www.goapa.org

Dear Families,

We are excited to announce a new partnership with Madison County Community Health Center that will allow your child to receive routine medical care from Board Certified physicians during the school day here at APA. This can include health physicals, vaccinations, wellness checks, dental appointments and more. MCCHC will be scheduling specific dates and times with us at each building for their school visit partnership which will be communicated to you as soon as it becomes available.

Our first visit will be for sports physicals and will be during the school day on **THURSDAY, 8/11/2016.** If your student has not received his or her physical for this school year and is interested in participating in fall sports, this must be taken care of immediately. All students in grades 5-12 who participate in a school sport MUST have a physical on file in order to do so.

MCCHC is able to bill your insurance for these services including HIP, Medicare, Medicaid, etc. They also will work with families using an income-based sliding fee scale and can assist families with getting signed up for programs like Healthy Indiana Plan (HIP) and more.

If you would like more information regarding options available, you can contact the Madison County Community Health Center directly at 765-641-7499 or find more information available on their website at www.mcchc.org.

In order for your child to receive services for his/her sports physical on **THURSDAY, 8/11/2016**, it will be necessary for you to complete the attached consent forms.

Please have your student submit these forms directly to Nurse Orr.

We look forward to being able to provide more services like these in the future.

Sincerely,

Commandant Barker

Madison County Community Health Center
Permission for Treatment with Non-custodial Parent or Guardian

I ______________________ give permission to allow APA - School ______________
(Full name of Parent/Guardian) *(Name & relationship to child or parent)*

to accompany my child ______________________ to the Madison County Community
(Child's full name)

Health Center, and to obtain treatment for my child on my behalf. Such appointments may consist of: examinations, vaccinations, or any other treatments deemed necessary by certified medical staff. This notice will be effective until: ______________________
(Date of expiration)

Child's Full Name ______________________________

Parent/Guardian's Full Name: ______________________________

Witness ______________________ Date ______________________
(Staff member of MCCHC)

HOPE. TRUST. HEALING.

Madison County Community Health Centers
CHAP Consent/Registration Form

Patient Information (PLEASE PRINT)

First Name: ______________________

Middle Name: ______________________

Last Name: ______________________

Address: ______________________

____

City: ______________ State: ___ Zip: ________

Home Phone #: ______________________

Social Security #: ______________________

Birth Date: ______________________

Gender ☐ Male ☐ Female **Language** ☐ English ☐ Spanish ☐ Other

Last Dental Appointment: ______________________

Race ☐ African American ☐ Hispanic ☐ Caucasian ☐ Asian ☐ Other

Homeless: ☐ Yes ☐ No

Child's Primary Physician

Doctor: ______________________

School: ______________________

Grade: ______________________

Parent or Guardian Info

Name: ______________________

Address: ______________________

Phone #: ______________________

Birth Date: ______________________

Relation to Patient: ______________________

Social Security #: ______________________

Email: ______________________

Primary Insurance (Medicare, Medicaid, Other)

Name of Company: ______________________ Effective Date: ____________

Insured Person's Name: ______________________ Insured Person's Birth Date: ____________

Insured Person's Address: ______________________ SSN: ____________

City: ______________ State: ________ Zip: ________ Phone#: ____________

ID Number ______________________ Group Number: ____________

Patient Relation to Insured Person: ______________________ *Scan Insurance Card (front & back).*

Secondary Insurance

Name of Company: ______________________ Effective Date: ____________

Insured Person's Name: ______________________ Insured Person's Birth Date: ____________

Insured Person's Address: ______________________ SSN: ____________

City: ______________ State: ________ Zip: ________ Phone#: ____________

ID Number ______________________ Group Number: ____________

Patient Relationship to Insured Person: ______________________ *Scan Insurance Card (front & back).*

PARENT/GUARDIAN PERMISSION AND RELEASE

I give permission for my child to participate in Project C.H.A.P.

(Please initial the statements below as you read them)

____ I understand that a provider from one of the participating health partners will perform the different assessments that my child receives. These assessments include hearing, vision, oral/dental, lead, diabetes, asthma, and pediculosis screening, age appropriate health education, and a physical exam (if I desire).

____ I give permission for all health partners participating in this program to share, with each other, any health assessment information about my child, for the purposes of having a complete health assessment record – this would also include the recommended follow-up health information.

____ I understand that it will be my responsibility to take my child to his/her doctor/clinic, eye doctor, or dentist if follow-up care is recommended.

____ I give permission to send my child health screening record to the doctor/clinic listed above and to the school so that it may be added to my child's primary health chart.

____ I give permission to bill Medicaid/Hoosier Healthwise for these services, if appropriate, and to provide them with any information about my child's health assessment record that would be needed for the purposes of billing.

____ I give permission for all partners in this program to utilize information from my child's health assessment record to be used for informing the community about services offered to the children of Madison County. My child's name or any identifying information would not be used.

____ I give unlimited permission to all of the partners in Project C.H.A.P. to use, publish, and republish, any reproductions of my child's picture (still or video), voice, or written words.

Patient\Guardian Signature: ______________________ **Date** ____________

I hereby consent to all treatment deemed necessary by the medical, behavioral health & dental staffs of Madison County Community Health Center. I authorize the release of any information necessary to process this claim. I request that any money due me for medical benefits be assigned to Madison County Community Health Center, and I realize that I am responsible for any and all differences. I have received the Notice of Privacy Practices and agree to its terms. I agree to pay my fee at the time of service. I grant permission for third party auditors, to view private health information as a part of the evaluation process. I further attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verify my income level is truthful. All information on this form is truthful to the best of my knowledge and if there are changes to my income, insurance status, or other information I will inform Madison County Community Health Center.

Staff Signature ______________________ Date ____________

Child's Name: ______________________ Age _____ Sex: M___ F___

1. Has your child had a complete physical exam in the last 12 months? Y N
2. Has your child had a complete dental exam in the last 12 months? Y N
3. Has your child had a complete eye exam in the last 12 months? Y N
4. List any medication your child is presently taking. ______________
5. List any allergies to food, medication or insects. ______________

Has your child ever had any of the following

	Yes	No		Yes	No
Asthma			Heart Disease		
Chicken Pox			Kidney Disease		
Depression			Seizures		
Diabetes			Vision Problems		
Ear infections			Other:		

Do you or anyone in your child's immediate family have any of the following

	Yes	No		Yes	No
Asthma			High Blood Pressure		
Cancer			Kidney Disease		
Diabetes			Mental Disorder/Depression		
Substance Abuse			Tuberculosis		
Heart Disease			Other:		

Explain any "yes" answers: ______________________________

HIPAA PRIVACY

You have permission to **(please check all boxes that apply)**

□ Leave messages on home voicemail/answering machine

□ Leave messages at parent/guardian's work **number** ______________

We may release/discuss the following protected health information:

☐ Medical Health ☐ Substance Abuse ☐ Behavioral Health

With the following individuals: **Choose one** and **Write Name and Phone number** please

□ Husband: ______________

□ Wife: ______________

□ Mother/Father: ______________

□ Other: ______________

□ Son: ______________

□ Sister: ______________

□ Brother: ______________

You are responsible for notifying this office if the above circumstances change. ***Thank you.***

ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I have read or received a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Joint Notice may be changed at any time. I may obtain a revised copy of the Joint Notice by calling 765-641-7499 Ext 273 or by requesting one at the office.

As the representative of the above individual, I acknowledge receipt of the Joint Notice on his or her behalf.

______________________________ ______________________________

Print: Parent/Guardian **(Relationship)** Parent/Guardian's signature

______________________________ ______________________________

MCCHC Staff Date