CIFC Health

Ms. Katherine M. Curran, Esq.
President & Chief Executive Officer

Dr. Jennifer Cohen, M.D.
Chief Medical Officer

Alan J. Clavette, CPA
Board Chair

Marlene Moranino RN, MPA
Chief Program Officer

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Greetings Parent/Guardian:

As a student at Henry Abbott Technical High School, your child is eligible to receive medical and mental health services offered during school hours through an on-site CIFC Health **School Based Health Center (SBHC)**.

The CIFC Health SBHC is *different* from the school nurse office and school guidance/social work office, as it is staffed by an outside, non-profit entity, CIFC Health. CIFC Health is a federally qualified health center with headquarters in Danbury and has SBHCs throughout the region. The CIFC Health Site at Henry Abbott Tech is staffed with a licensed nurse practitioner and a marriage and family therapist who are available to provide care to your child just as a private doctor or mental health provider's office would. The CIFC Health SBHC can serve as a primary care provider (PCP) to your child if your child does not have a PCP *or* can supplement the work of your child's primary care doctor by offering services on site at school and by diagnosing and treating illnesses early without having to leave school.

On-site **medical services** include:

Complete physical exams, vaccines, diagnose and treat common illnesses such as ear infections, headaches, pneumonia, rashes, strep throat, allergies, health education for nutrition, exercise, weight, asthma education, and inhaler refills. Providers can send prescriptions for medications directly to your pharmacy.

Mental health services include:

Assessment for individual, group, and/or parent family therapy, assistance with peer/family relationships, anxiety/depression, behavior problems, exposure to trauma/loss, poor academic performance/learning challenges, history of or current self-harm and suicidal ideation, and transition to new home/school location.

To use the above services, parent/guardian must complete, sign, and return to the SBHC, the attached 2-sided **School-Based Health Center Permission Form**, and attach a current copy of the front and back side of your child's insurance card. All information must be completely entered into the form or it will be returned to you.

As we are a healthcare provider subject to legal and regulatory compliance requirements, all insurances will be billed for all eligible medical or mental health visits, and invoices for co-pays and/or deductibles will be sent home following future scheduled visits. Again, this is because we are just like a regular doctor's office that happens to be located in your child's school.

If your child is not currently covered under a health insurance plan, please notify the SBHC and an appointment will be made with CIFC Financial & Insurance Assistance, for assistance with enrollment in the CT HUSKY Insurance Program, or to be placed on a sliding-fee scale payment plan.

If you have any questions about the CIFC Health SBHC, please call 203-797-4406, ext. 12922. Completed CIFC Health SBHC Permission Forms can be faxed to 203-797-2788.

On behalf of the staff at the Henry Abbott Technical High School, CIFC Health SBHC, we look forward to assisting your child to be healthy, happy, and ready to learn!

School Based Health Center (SBHC)
Permission and Medical History Form

Student's Name: _____ Date of Birth: _____

1) Is the student under the care of any medical specialist? ☐ Yes ☐ No

2) Has student seen a dentist within the last year? ☐ Yes ☐ No

3) Has student seen same dentist for more than one year? ☐ Yes ☐ No

4) Is the student currently taking any medications? ☐ Yes ☐ No
If YES, please list below including dosages and how often. (Include asthma inhalers and EpiPens) _____

5) Do you have allergies? (food, medication, bees, etc.) ☐ Yes ☐ No
If YES, please specify: _____

Medical History: *Please check all boxes that apply and explain on the lines below:

- ☐ Hospitalization or Surgery
- ☐ Seasonal / Environmental Allergies
- ☐ Broken bones, Dislocations
- ☐ Muscle or Joint Injuries
- ☐ Neck or Back Injuries
- ☐ Heart Defects / Murmurs
- ☐ High Blood Pressure / Cholesterol
- ☐ Chest Pain during or after exercise
- ☐ Fainting or Blacking-Out
- ☐ Running / Exercise Problems
- ☐ Asthma / Breathing Issues
- ☐ Blood Disorders / Anemia / Sickle Cell
- ☐ Vision Problems (Contacts / Glasses)
- ☐ "Mono"
- ☐ TB or Positive Skin Test
- ☐ Skin Problems (Eczema, Psoriasis)
- ☐ Dental Problems (Pain / Bleeding)
- ☐ Concussions
- ☐ History of Seizures
- ☐ Headaches / Migraines
- ☐ Diabetes/Thyroid/Endocrine
- ☐ Weight or Eating Issues
- ☐ Females: Menstrual problems
- ☐ Stomach Problems
- ☐ Hearing Problems
- ☐ Any other medical problems

_____

_____

Mental Health History: *Please check all boxes that apply and explain on the lines below:

- ☐ Mood Disorder / Depression
- ☐ Anxiety / Panic / OCD
- ☐ Anger / Other behavioral issues
- ☐ Academic Concerns
- ☐ Cutting / Self-harm
- ☐ Learning Disorder / ADD / ADHD / Autism Spectrum
- ☐ Loss / Divorce / Deportation of family members
- ☐ Substance use / Vaping
- ☐ Eating / Significant Weight Loss or Gain
- ☐ Other unlisted concerns

_____

_____

Family History: *Please check all boxes that apply and explain on the lines below:

- ☐ Family member with heart disease
- ☐ Family member with high cholesterol
- ☐ Family member with diabetes
- ☐ Family member with mental illness (i.e. depression)
- ☐ Family members with alcohol / drug problems
- ☐ Family medical problems not addressed above

6) Has any sudden family member died of heart problems or sudden death before age 50? ☐ Yes ☐ No
Please specify which family member (Maternal / Paternal): _____

_____

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

I give permission to the CIFC Health School Based Health Centers and Henry Abbott Technical High School to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment, and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing.

I received the HIPPA Notice of Privacy Practices Notice ☐ Yes ☐ No

Date: _____ Signature : _____ Relationship to student: _____

CT Institute for Communities

CIFC Health

AGREEMENT BETWEEN OUTPATIENT AND PATIENT OR PARENT/GUARDIAN

Patient Name _____ DOB _____

Parent/Guardian Name	
Address	
Telephone Number(s)	

Person who will transport the client to and from appointments: _____
(☐ If same as above, check here.)

Parent/guardian understands that they must remain in the Behavioral Health Dept. while the child is attending an appointment.

Children at the School-Based Health Center: Clinicians will follow the School and school district policy when service is completed at the SBHC site.

I understand that there are not any medical procedures conducted by the behavioral health staff. Should medical assistance be required I will assume responsibility for seeking such treatment. Should an emergency occur, an ambulance will be called.

I understand that no medications will be administered by the behavioral health staff

I have received a paper copy of the Patient Rights and Responsibilities. I have been instructed to contact the site manager if I have any questions.

I have been given a paper copy of the Notice of Privacy Practices.

I understand that all staff are mandated reporters and are required to report suspected child abuse and neglect (as described by CT statutes; 17a-101;). I understand that my

PLEASE REVIEW, SIGN AND DATE THE BACK OF THIS SHEET

confidentiality may be waived if I express an intention to harm myself, harm another, commit a crime, or if I am experiencing child or elder abuse, or am gravely disabled.

Information will be released after signing a release of information form. If I sign a release of information form, I will do so of my own free will. The release will expire within one year; however, I may withdraw the release at any time without prejudice.

I understand that to file a complaint I must register my complaint in writing with the Behavioral Health Site Manager or the Privacy Officer. A complaint form will be provided to me by Behavioral Health staff when requested. I understand that my complaint will be investigated, and I will receive a response within 30 days.

I understand that I am responsible for payment of my session at the time of each session. If I have made payment arrangements, I understand that I am responsible to make such payments. I understand the fee which I will be charged for each session. **NOT APPLICABLE TO SBHC.**

I have been provided with the business hours of the behavioral health clinic at CIFC Health, Health Center. I also understand that if I am experiencing an emergency, I should call 911 or go to the closest hospital emergency room.

I understand that when I arrive for my appointment I must check in at the front desk and make a payment (if applicable), and when I am leaving, I must check out at the front desk to make an upcoming appointment. **NOT APPLICABLE TO SBHC**

I understand that if I need to cancel an appointment after hours, I will leave the information with the answering service at **(your school number)**

All of the above information was reviewed with me by clinic staff.

_____ _____

Patient Signature (age 5 and older must sign) Date

_____ _____

Parent/Guardian Signature Date

_____ _____

CIFC Health Representative Date

CT Institute for Communities

CIFC Health

120 Main St., Danbury, CT

Pediatric Behavioral Health Department at CIFC Health

INFORMED CONSENT

Patient: _____ DOB: _____

I hereby voluntarily request and authorize CIFC Health Pediatric Behavioral Health to render the psychiatric services listed below, as clinically appropriate, to the child.

Services may include:

- Individual therapy
- Family therapy
- Group therapy
- Psychiatric evaluation
- Medication evaluation
- Care Coordination/Care Facilitation (such as referrals to community programs, insurance or other entitlement assistance, etc)
- Telehealth and Telephonic Services: Virtual Behavioral Health services

The individual treatment plan describes in specific terms the treatment for which the consent is given and is signed by patient/guardian.

I understand that my provider is available to answer any questions I may want to ask. I understand that I have the right to question or refuse any treatment at any time.

While receiving services in the Pediatric Behavioral Health Department, a treatment plan will be created that outlines treatment goals, discharge criteria, frequency of services as well as interventions. These will be reviewed with me on a routine basis. I understand that I have the right to request an internal review of my plan of care, treatment, or services.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian Date

CIFC Health (please print clearly)

Patient Information

Last Name | First Name | Middle Initial | Date of Birth: month/day/year

Street Address: | Unit # | City | State | Zip Code

Phone 1: Primary Contact? ☐ | Phone 2: Primary Contact? ☐ | Student's Cell Phone Primary Contact? ☐

Phone 1 is OK for CONFIDENTIAL messages: ☐YES ☐NO | Phone 2 is OK for CONFIDENTIAL messages: ☐YES ☐NO | Student's Cell is OK for CONFIDENTIAL messages: ☐YES ☐NO

How do you want to receive reminders and notifications? ☐Text ☐Voice Message (if voice message, select: ☐Home ☐Cell ☐Work)

Contact

Emergency Contact 1: Name: | Relation: | Phone 1: ☐Cell ☐Home ☐Work | Phone 2: ☐Cell ☐Home ☐Work

To Medical Contact 1, CIFC Health can:
1) Disclose your medical information? ☐YES ☐NO
2) Leave a detailed message with them? ☐YES ☐NO
3) Contact this person in an emergency? ☐YES ☐NO

Emergency Contact 2: Name: | Relation: | Phone 1: ☐Cell ☐Home ☐Work | Phone 2: ☐Cell ☐Home ☐Work

To Medical Contact 2, CIFC Health can:
1) Disclose your medical information? ☐YES ☐NO
2) Leave a detailed message with them? ☐YES ☐NO
3) Contact this person in an emergency? ☐YES ☐NO

Do you have health insurance? ☐YES ☐NO

Can we help you apply for?
☐Husky/Medicaid ☐Health Insurance - Access Health CT
☐Financial Assistance - Our in-house sliding-fee scale program

Which pharmacy do you use?

Who is your primary care provider (PCP)?

Insurance

Primary Insurance: Company Name | ID# | Group #

Policyholder Info: *Check here if patient is the primary:* ☐ *If someone else, fill out below*

Last Name | First Name | Date of Birth (month/day/year) | Relationship to patient

Street Address (Check here if address is same as patient ☐) | Apt/Floor | Town | State | Zip Code

Secondary Insurance: Company Name | ID# | Group #

Policyholder Info: *Check here if patient is the primary:* ☐ *If someone else, fill out below*

Last Name | First Name | Date of Birth (month/day/year) | Relationship to patient

Street Address (Check here if address is same as patient ☐) | Apt/Floor | Town | State | Zip Code

*Required Information

Sex assigned at birth:
☐Male
☐Female

Marital Status:
☐Single
☐Seperated
☐Divorced
☐Married
☐Together
☐Widowed

Are you Homeless?
☐YES (Select below) ☐NO (Skip below)
- ☐Doubling-up (living with another family)
- ☐Street
- ☐Homeless Shelter (temporary/overnight stay)
- ☐Transitional (Longer temporary housing)
- ☐Other: _____

Language Preference:
☐English ☐Portuguese
☐Spanish ☐Other:_____

Employement Status:
☐Retired
☐Employed- Full time
☐Employed- Part time
☐Self-Employed
☐Unemployed
☐Student-Full Time
☐Student-Part Time

Ethnicity
select all that apply
Hispanic/Latino:
☐Yes, from which country?_____
☐No ☐Decline to answer

Race
select all that apply
☐Asian: from which country?_____
☐Native Hawaiian
☐Other Pacific Islander
☐Guamanian or Chamorro
☐Samoan
☐Black/ African American
☐Native American/ Alaskan
☐White
☐Decline to answer

Other questions: (required)

Do you want a translator:
☐YES
☐NO

Are you a Veteran?
☐YES
☐NO

Access

E-mail:

This email grants you access to your health information, including appointments & visit notes. You can use your secure account in a web browser or our encrypted mobile app.

If you DO NOT WANT TO BE ABLE access to your health information this way, you can DECLINE YOUR ACCESS by checking this box: ☐

Income

CIFC Health receives Federal Grants which require us to ask for this information.

How many people are in your household? | Household Income: $

☐Weekly: How many weeks do you work each year?
☐Monthly: How many months do you work each year?
☐Annually

Signature of Patient/Guardian: _____ **Date:** _____

Financial Agreement & Assignment of benefits:

- I authorize the submission of a claim for Payment to Medicare, Medicaid or any other payer for any services provided to me or my children under 18 years of age as listed on the demographic sheet, now, in the past or in the future.
- I understand and agree that I am ultimately responsible for the balance for myself and all my identified children under 18 years of age as listed on the demographic sheet for any professional services rendered and in some cases, may be responsible for an amount in addition to that which was paid by my insurance.
- I authorize payment of my medical benefits to be sent directly to CIFC Health or it's individual providers for services rendered for me and all my identified children under 18 years of age as listed on the demographic sheet. Should my insurance claim be denied for lack of eligibility or termination of coverage, I understand that I will be held responsible and intend to make payment for any balance due in those instances.
- I authorize CIFC Health to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to CIFC Health and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by CIFC Health, in the past, now or in the future.

Person Responsible for Payment: ☐ Patient ☐ Parent/Guardian ☐ Spouse ☐ Other:

Last name	First name	M.I.	Phone	Date of Birth: (month/day/year)

Street Address (Check here if address is same as patient ☐) Apt/ Floor Town State Zip Code

Signature of Patient/Guardian: _____ **Date:** _____

Authorization to Treat

- I hereby give permission to the staff of the CIFC Health Center to provide medical, dental, and behavioral health treatment, and vaccine administration.
- For emergency situations when I cannot be reached, I give permission for my minor dependents to be treated for the emergency conditions.

Signature of Patient/Guardian: _____ **Date:** _____

Health Records

I hereby authorize CIFC Health to obtain my health information, including utilizing electronic health information exchange entities (HIEs), whereby my health information may be received from and/or shared with external healthcare service professionals electronically for the purpose of my healthcare.

Signature of Patient/Guardian: _____ **Date:** _____

If you DO NOT wish to participate with Commonwell/Carequality you can DECLINE by checking this box: ☐

CIFC Health may obtain my medical records:

☐ **Yes-** Authorization form attached.

☐ **NO** - I do not wish to release past and present medical information to CIFC Health.
NOTE: Missing medical record information, as well as the patient's health history, increases the risk of complications during treatment.

Please select the SBHC the studen't is enrolling in:

☐ Henry Abbott Technical High School P: (203)731-8274 F: (203)731-8275

Grade/Cluster _____

Is the student on the free or reduced lunch program?

☐ Yes ☐ No