TCAPS E3 Program Intake & Consent Form

Student's Name: ______________________________ Date of Birth: ____/____/______

Address:______________________________City:______________State:________ Zip:____________

Grade:__________School:______________________________ Male__________ Female ______________

Legal Guardian Name:______________________________Relationship to Patient: ____________

Guardian Date of Birth:_____/_____/_____Phone: ________________

Legal Guardian Name:______________________________Relationship to Patient: ____________

Guardian Date of Birth: _____/_____/_____ Phone Number: ________________

Name of Patient's Insurance:______________________________Beneficiary ID#:______________

Insurance Address:______________________________Insurance Phone Number: ______________

Subscriber's Name:______________________________Subscriber's Date of Birth: __________

Subscriber's Social Security Number: ______________________

Total Annual Family Income. (Please circle appropriate box)

1 member	$0 - $15,650	$15,651 - $23,475	$23,476 - $28,953	$28,954 - $31,300	> $31,300
2 members	$0 - $21,150	$21,151 - $31,725	$31,726 - $39,128	$39,129 - $42,300	> $42,300
3 members	$0 - $26,650	$26,651 - $39,975	$39,976 - $49,303	$49,304 - $53,300	> $53,300
4 members	$0 - $32,150	$32,151 - $48,225	$48,226 - $59,478	$59,479 - $64,300	> $64,300
5 members	$0 - $37,650	$37,651 - $56,475	$56,476 - $69,653	$69,654 - $75,300	> $75,300
6 members	$0 - $43,150	$43,151 - $64,725	$64,726 - $79,828	$79,829 - $86,300	> $86,300

Ethnicity (Please circle)

Are you Hispanic or Latino? ☐ Yes ☐ No

Race (Please circle)

Asian
Native Hawaiian
Other Pacific Islander
Black African American
American Indian/Alaska Native
White
More than one race

Are you homeless? ☐ Yes ☐ No

If yes, please circle:

Shelter Street
Transitional Housing Doubled
Up
Other (hotels, day to day housing) Unknown
(homeless/none of the above)

Do you (the parent or guardian) work in Agriculture?

☐ Migrant Agriculture ☐ Seasonal Worker ☐ None

1. We provide enrollment assistance to uninsured and underinsured to obtain health insurance. Would you like us to contact you about this? _____Yes _____No

2. Is English your primary language? _____Yes _____No

   If no, what language are you best served in? ______________________________

Medical and Mental Health History

Name of Primary Care Provider:______________________________Telephone: ____________________

Medical and Mental Health History

Student Name: ________________________

By signing this form, I acknowledge the following:

☐ **Consent for Treatment – Behavioral Health Services:** I hereby give consent to my child and authorize all diagnostic and therapeutic treatment performed at Northwest Michigan Health Services, Inc. (NMHSI). I acknowledge that behavioral health services are available upon request. These services include but are not limited to, individual counseling, family counseling, substance abuse counseling & referral, physical and sexual abuse counseling & referral. I understand that all healthcare information is confidential. Confidentiality between the student, parent/guardian and the therapist are assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The CAHC staff will encourage every student to involve his/her parent/guardian in health care decisions. *According to Michigan law, students 14 years or older can receive confidential counseling services. They do not need to have parental consent. Under extreme circumstances, a student's right to privacy may be waived. No abortion counseling or referrals can be provided.*

☐ **TCAPS E3 Program:** Traverse City Area Public Schools E3 Program may include **Behavioral Health and referrals to a Community Health Worker. Behavioral Health Services** will consist of the following: treatment, assessment, and individual counseling. **Community Health Worker (CHW)** will act as a community resource connector offering programs to assist those in need, including Medicaid Enrollment. I understand that NMHSI Child & Adolescent Health Center Staff will have access to view records, including PowerSchool system. I understand NMHSI Child & Adolescent Health Center Staff will release limited information to school staff and its subcontractors for appointment coordination purposes related to Child & Adolescent Health Center Services.

☐ **Authorization for Payment Agreement:** We participate with many insurance carriers including Medicare and Medicaid. As a courtesy to you, we will bill your insurance carrier directly for our services. You may be responsible for fees we do not collect. I authorize any insurance benefits to be paid directly to Northwest Michigan Health Services, Inc. realizing I am responsible to pay non-covered services. I agree that services are provided to anyone between the ages of 10-21, and their infants and young children, regardless of their ability to pay. There is a sliding fee scale for those without insurance.

☐ **Release of Information:** I authorize that Traverse City Area Public Schools E3 Program may disclose my behavioral health records to any third-party payers, including, but not limited to, health insurers, health care service plans, welfare agencies, and worker's compensation carriers. NMHSI will follow federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and the Michigan Mental Health Code. I am aware and agree that NMHSI and referring providers are authorized to share information with each other including financial and/or behavioral health records, information related to drug use, alcoholism, psychiatric care, or other diagnoses that may be concerned sensitive by some. This consent for release of behavioral health, or financial information is subject to revocation at any time, except to the extent that action has already been taken.

☐ **Exchange of Information:** I authorize the exchange of information between school officials and clinic staff enabling my child to receive the best available services. Information might include medical, educational, and /or mental health information only as necessary to ensure your child's safety and well-being on a "need to know" basis. I understand that Traverse City Area Public Schools E3 Program staff may access school records for the purpose of coordinating services and for overall program evaluation and may include academic, discipline, and absence data. We understand and value you and your child's privacy.

☐ **Authorization for Payment Agreement:** We participate with many insurance carriers including Medicare and Medicaid. As a courtesy to you, we will bill your insurance carrier directly for our services. You may be responsible for fees we do not collect. I authorize any insurance benefits to be paid directly to Northwest Michigan Health Services, Inc. realizing I am responsible to pay non-covered services.

Privacy Practices Notice: I acknowledge being offered a copy of the Northwest Michigan Health Service, Inc. Notice of Privacy Practices which is available at www.NMHSI.org or by request.

If patient is under the age of 18: Please complete Authorization for Treatment of Unaccompanied Minor

Authorization for Treatment of Unaccompanied Minor:

☐ **Yes** ☐ **No** I hereby authorize Northwest Michigan Health Services, Inc to provide Behavioral Health treatment to the unaccompanied above-named minor child.

Parent/Guardian Printed Name and Relationship: ____

Signature:____ **Date:** ____________________

(If under 18, must be signed by parent or guardian)