The Humboldt IPA School Based Wellness Centers and Programs

Phone: (707) 382-4231 Fax: (707) 267-2527

What is a School Based Wellness Center?

School Based Wellness Centers (SBWC) aim to improve access to services and academic success by bringing wellness services to the school site. Examples of SBWC services include access to services that promote wellness; these include a drop-in center available to students and their families during regular school hours and Empowerment groups, consent not required for these services. The Wellness Center is a safe space offering universal, prevention services for students and their families.

Wellness Center Drop in Services includes the following (Consent not required for these services):

- Hygiene supplies
- Washer and dryer services
- A clothing closet
- Food (Dried goods, and snacks)
- A safe space for students to recharge
- Referrals to community services

The Humboldt Independent Practice Association (Humboldt IPA) sponsors the School Based Wellness Center. For more information about the health center or programs or if you have any questions please call: 707-442-0478 ext. 152

Description of Services that require parent/guardian consent

The Humboldt IPA's School Based Wellness Centers are designed to be a safe space for students during times of stress and need. Through our programs, students have the access to our trained staff members who will work with everyone to support their needs and help them achieve success. We offer students opportunities to strengthen their wellness and resiliency skills through one-on-one support, Brief Intervention Services, conflict mediation and more. Our Wellness Center's emphasis on prevention helps reduce the risk of trauma exposure and ensure timely interventions. Additional intensive case management services are offered to students with higher or complex social needs. Case management services include home visits with the student and families as needed. Additional case management services may be covered by your health insurance, we would like to collect any health insurance information to determine of additional services are available.
Parent/Guardian consent is needed for all case management services.

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ENROLLMENT AND CONSENT FORMS

STUDENT INFORMATION

Student Name: _____DOB: _____

Gender: M☐ F☐ Other☐

Address: _____

Phone Number: _____

Health Insurance: _____

Subscriber Name: _____

ID and Group number: _____

CONSENT FOR SCHOOL BASED WELLNESS CENTER (SBWC) SERVICES

I, the parent/guardian of _____,
give consent for my child to receive services at the Wellness Center.

_____
Parent/Guardian Signature Printed Name

_____
Relationship

Daytime phone #_____

Name of Alternate Contact

_____
Printed Name Relationship

Daytime phone # _____

Release of Information

All healthcare/social care information is confidential. By signing this release of information consent form you are giving the SBWC staff, school nurse, school counselor and other school staff permission to communicate and share information regarding your child on an as needed basis with the understanding that this information will continue to be treated in a confidential manner.

Confidentiality between the student, parents and the wellness center is assured. By law, some information requires the student to give signed consent prior to disclosure to anyone, including parents/guardians.

In addition, I give consent for the school staff to share student demographic, IEP, 504, SST and/or nursing care plans with the SBWC staff for the purposes of providing wellness services.

I am the legal guardian of the above-named child. I understand that if guardianship changes a new consent must be signed by the new legal guardian.

_____

Students Name Date of Birth

_____

Parent/Guardian Signature Printed Name Date

Text Messaging Communication Consent

By signing below, I give consent to the Humboldt IPA SBWP to communicate with me and my child regarding services provided through the Wellness Center and its services and programs. I understand that the IPA/SBWP is not responsible for the security of my text messages. Text messages can be intercepted, spied upon and otherwise accessed without my consent. It is my responsibility to inform the SBWP of changes to my text message number. The IPA SBWP is not responsible for any disclosure that occur because I don't inform them of the change in number. The IPA SBWP is not responsible for any charges I may incur from data overages. I may opt out of text messaging at any time in writing.

I understand that the above statements and consent to text messaging with me and/or my child.

_____

Parent/Guardian Signature Printed Name Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I/my child have certain rights to privacy regarding protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Parent/Guardian Signature Printed Name

_____

Date

Student Last Name_____ Student DOB: _____

North Coast Care Connect

The Humboldt IPA School Based Wellness Programs works with your student's school to offer additional services on the campus. These services include Empowerment Groups, supportive services and one on one support. We use North Coast Connect as our documentation platform as well as all of the navigation support tools within North Coast Connect.

Introduction to the North Coast Care Connect - "Care Connect"

The North Coast Care Connect is a network of health and social service providers who have partnered together to coordinate care for persons in need of assistance. When persons opt-in to share their information with the network, Partner Agencies are able to share client information using a secure data platform and to provide coordination and electronic referrals for services.

To participate in the network, you must give your permission to share your information in the network and chose how the sharing would work.

Information sharing work in the network – there are four choices

- If you allow participation with the full CIE network, providers at Care Connect agencies can make referrals and contact other network providers on your child's behalf and share your child's information to provide services to your child or to refer your child to other providers and programs in the North Coast Region.

- If you allow participation with only Care network providers approved by your current network team members, then only those agencies can make referrals and share your child's information to provide services to your child or to refer your child to other providers and programs in the North Coast Region.

- If you allow participation with only network providers you approved, then only those agencies can make referrals and share your child's information to provide services to your child or to refer your child to other providers and programs in the North Coast Region.

- If you allow participation with only to a single agency there would not be care coordination or sharing of your child's information with other agencies or programs (no authorization for network service providers). Each referral for service will require you to provide much of the same information

Please choose how your child will participate in North Coast Care Connect.

□ Yes, I want to participate in the full Care Connect network.
□ Yes, but only with service providers approved by my child's care team
□ Yes, but only with service providers I approve (will need email or text correspondence)
□ No, I don't want to participate in the network.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION
North Coast Care Connect

You may revoke your authorization at any time. (Contact the SCWC for the form)

The North Coast Health Improvement and Information Network (NCHIIN), dba North Coast Care Connect is focused on improving the health and wellbeing of all residents of Humboldt County. The North Coast Care Connect (Care Connect) is a partnership of health, social, and community services organizations that help you get services, work with you to understand your needs, and connect you to resources that can help you. Your permission is needed to allow sharing of your protected health information and other personal information, including through electronic systems used by North Coast Health Improvement and Information Network (NCHIIN) and participating organizations. Granting permission allows your providers to communicate better with each other to provide you better care. If you agree, your information will be stored and shared with (to and from) the following types of organizations to help the coordination of your care, resources, and human services:

- Health care providers
- Behavioral health providers
- Social services providers
- Health plans
- Housing providers
- Organizations involved with the justice system
- Community organizations, for example, food banks, legal services
- County Departments, for example, The Department of Health and Human Services
- Wellness and others

A current list of Participants, which may change from time-to-time, can be found at https://www.nchiin.org/cie

Sharing information makes it easier to see if you are eligible for resources, get referred to services and care, and take part in programs from organizations in Humboldt County to improve your health. It also makes it easier for your providers to coordinate your care, receive payment for services, conduct program work, and improve the quality of services. For more information on how Care Connect uses and protects your information, and how to get a copy of this Authorization for your records, please view the Care Connect information page at https://www.nchiin.org/cie

Signing this form is your choice. No matter what you choose, it will not change your ability to receive services.

By signing this form, you are giving permission for your information including information disclosed and re-disclosed by you, your family, to be shared with (to and from) the types of organizations shown above. It will be used to see if you are eligible for resources, help link you to them, and help coordinate between them to better serve you.

By signing my name below, I agree that my current, past, and future treating providers and organizations may disclose my health information, records, social services information, and other data to NCHIIN and that such data may be shared among and between the North Coast Care Connect participating organizations.

- Information that may be shared will include but not be limited to information about:
    - my personal characteristics, for example name, date of birth, housing status, and contact information,
    - my medical history, mental or physical condition,
    - my social service information (including CalFresh, General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, and other public benefits that I may apply for), and
    - treatment and services I receive.

- I understand that this Authorization will apply to data from all services I receive from Care Connect providers and partners.

I specifically authorize my current, past, and future treating providers and organizations, NCHIIN, and Care Connect participating organizations to share the following information (*check as appropriate*):

☐ Mental health treatment information (excluding psychotherapy notes) _____ (*initial*)

☐ Information about my HIV/AIDS test results _____ (*initial*)

I understand:

- This authorization will remain in effect for a period of one (1) year from the date this is signed, or until I change or revoke my authorization in writing.
- I have the right to cancel or change this authorization at any time. I can start this process by talking with any of my Care Connect providers. (A verbal or written notice to revoke your consent will be processed within five business days.) At that time, I will either cancel my authorization or complete a new authorization to reflect the change(s) to the sensitive information that I want to share. If I limit my information sharing, my sensitive information will not be shared with partnering providers or organizations from that date forward. Any sensitive information previously shared with current or past treating providers cannot be recalled. Should I elect not to share any sensitive information, I may receive limited care coordination services through the North Coast Care Connect system but does not affect services from the providers.
- When my information is shared, there is a chance it will be re-shared with others. Federal law or California privacy law may not protect the re-sharing of my information.
- I have the right to:
    - Inspect or obtain a copy of my health information and social services information that is shared by this authorization
    - Refuse to sign this authorization
    - Receive a copy of this authorization

I have read this authorization or my provider has read it to me. I authorize the use

and sharing of my health and social services information as described above.

_____ _____
Client Signature Date

_____
(Print first name, middle name and last name of individual)

Date Authorization and Consent Expires_____

If this Authorization is signed by a person other than the client, please indicate the relationship:

_____
Relationship to Client

_____ _____
Name Date