Community Health & Wellness Center (CHWC) School Based Health Center (SBHC) program is in the Torrington Public Schools and Oliver Wolcott Technical High School. We provide Primary care, Behavioral Health and social services to students with no out of pocket expenses for the family.

Goals: The goals of the SBHC APRNs are twofold. One, is to be a collaborative practitioner with the local pediatricians. Two, is to promote healthy behaviors and healthy habits.

Objectives: Work with community pediatricians to enhance medical and behavioral health services. Students with an established pediatrician will be referred to their provider for continuity of care. Students may be referred to the SBHC from the pediatrician's office. The SBHC may also initiate the collaborative process. Services include:

- No out-of-pocket expenses
- Insurance will be billed
- Provide available, accessible, and confidential preventive and diagnostic health care
- Encourage health-promoting behaviors through education and counseling
- Assist students with developing a healthy physical and psychological lifestyle
- Early detection and treatment of conditions and illnesses
- Assist students with obtaining healthcare through referrals to community providers
- Address social determinants of health

Collaboration: SBHC professionals work closely with: Community Pediatricians, Families, School Nurses, Licensed Behavioral Health Clinicians, Counseling Departments, School Faculty, School Administration, Wellness Coordinators

Community Pediatrician collaboration includes:

- Dialogue and communication with the student's pediatrician
- Supplement and support for in-office care
- Assistance with monitoring, evaluating, and educating students

Eligibility: All students attending Torrington Public Schools and Oliver Wolcott Technical School

- Students under 18 years old, who are not emancipated minors, must present a Consent for Treatment Form and Release of Information Form signed by a parent or guardian

Pediatric Nurse Practitioner Scope:

- Chronic care management
- Wellness
- Health education
- School/Sports physicals
- Sick Visits
- Social determinants of health

Licensed Clinical Social Worker Scope:

- Mental Health Evaluation and Intake
- Individual Therapy
- Family Therapy
- Cognitive Behavioral Therapy (CBT)
- Behavioral Therapy
- Play Therapy

Community Health & Wellness
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PATIENT INFORMATION

Last Name:	First Name:	Middle:

Preferred Name:	Sex Assigned at Birth ☐ Male ☐ Female	Preferred Pronouns:

Parent or Guardians name if patient is a minor:

Address:	City:	State:	Zip Code:

Social Security #:	Date of Birth:	Email Address (By providing your email address, you agree to receive CHWC updates and notifications):

Primary Telephone	Home:	Cell:	Work:
Secondary Telephone	Home:	Cell:	Work:

Emergency Contact Name: Emergency contact can be contacted in the event we are unable to reach you for routine care:	Phone #:

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Other:

Sexual Orientation ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Chose not to disclose ☐ Other:

Gender Identity ☐ Trans female (MTF) ☐ Trans male (FTM) ☐ Male ☐ Genderqueer ☐ Gender nonconforming ☐ Female ☐ Gender fluid ☐ Choose not to disclose ☐ Other:

Race: **Circle all that apply**
☐ Native American ☐ Black / African American ☐ Asian ☐ Pacific Islander ☐ White ☐ Multi-Racial ☐ Do not identify ☐ Choose not to share ☐ Other:

Ethnicity: **Circle all that apply**
☐ Guatemalan ☐ Mexican ☐ Dominican ☐ Venezuelan ☐ Puerto Rican ☐ Cuban ☐ Not Hispanic / Latino ☐ Ecuadorian ☐ Other / Hispanic:

Language:
☐ English ☐ Spanish ☐ Other:

Is there anything else you'd like us to know about you (such as cultural or religious beliefs) concerning your medical treatment?

I would like help with: **Circle all the apply**
☐ None ☐ Choose not to share ☐ Food ☐ Housing ☐ Transportation ☐ Other:

Living situation:
☐ I have a steady place to live
☐ I have a place to live today, but I am worried about losing it in the future
☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Migrant Worker:
☐ Yes ☐ No ☐ Seasonal

Veteran:
☐ Yes ☐ No

Please turn over, read and sign

INSURANCE INFORMATION

Name of Primary Insurance:	Policy #:	Group #:
Subscriber Name:	Patients relationship to subscriber: ☐ Self ☐Spouse ☐ Child ☐ Other	
Name of Secondary Insurance:	Policy #:	Group #:
Subscriber Name:	Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

Preferred Pharmacy (Name, town, address):

Please complete the following information. We use this to offer you all programs and benefits you may qualify for.

Family size:_____ **Total Household Annual Income: $_____**

Fee Schedule 2023 Please choose a Federal Poverty Level based on your family size & income.

	<100% ☐	**101%-133%☐**	**134%-167%☐**	**168%-200% ☐**
1	$14,580	$19,391	$24,349	$29,160
2	$19,720	$26,228	$32,932	$39,440
3	$24,860	$33,064	$41,516	$49,720
4	$30,000	$39,900	$50,100	$60,000
5	$35,140	$46,736	$58,684	$70,280
6	$40,280	$53,572	$67,268	$80,560

Community Health & Wellness
Our Family – Taking Care of Yours

Authorization to Treat – Assignment of Benefits – Notice of Privacy Practices

- I hereby consent to being treated as a patient of Community Health & Wellness Center of Greater Torrington, Inc. (CHWCGT) at any CHWCGT location, including school-based locations when applicable, for the purpose of receiving medical, behavioral health or dental care and treatment and/or diagnostic procedures. I understand I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that a discussion of the risks, benefits and alternatives to each procedure or treatment will be available to me prior to each procedure or treatment.
- I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by CHWCGT and any third-party establishment necessary to perform business activities.
- I hereby authorize and direct my insurance carrier to make the payment of any benefits due directly to CHWCGT, and I understand any co pays, referrals, new insurance information, deductibles and denied services will be patient's responsibility as applicable. Copays will not be collected in our school-based programs.
- I understand my patient responsibility regarding payment for the services I receive from CHWCGT, and agree to provide new or updated insurance information as needed.
- CHWCGT is not responsible for any services I may receive at other facilities, which are not owned and operated by CHWCGT. Any charges from such facilities are the responsibility of the patient. For example: lab, x-rays, specialty care, etc.
- I acknowledge that I have received a copy of CHWCGT Notice of Privacy Practices that describes how medical information about me may be used and disclosed. I understand that I am entitled to updates to these Privacy Practices, and if I have any questions or complaints, I may contact the CHWCGT Privacy Officer.
- I understand CHWCGT may access my medical information, including diagnostic and screening results, from other care providers' electronic health record systems in order to provide treatment.
- I hereby consent to allow CHWCGT to retrieve information from a database that monitors when and who last prescribed medications to me.
- I understand that CHWCGT participates in health information exchange to enhance the quality of care provided to me. I acknowledge that I may opt out of information exchange at any time.
- As required by law, CHWCGT will share immunization information with the State of CT Department of Public Health (DPH). I understand I can opt out of this by sending a signed written request to the DPH Immunization Program.
- I have received a copy of my patient rights and responsibilities and understand my rights and responsibilities as a patient.

Patient Printed Name: _____Birthday: ____/_____/_____

Patient Signature: _____Date: ____/_____/_____

Guardian/POA/Parent/Conservator signature, if applicable

_____

HIPPA given on Date: ___/____/____

Revised 8.31.2023

WELCOME TO COMMUNITY HEALTH & WELLNESS CENTER

The Community Health & Wellness Center is committed to "providing quality, compassionate, and professional health care that is affordable, easily accessible and without discrimination to all residents" of the greater Torrington area. The center provides comprehensive primary and preventive health care regardless of your ability to pay.

AFTER HOUR COVERAGE

Any Community Health & Wellness Center patient that has an urgent matter but does not require emergency attention can call 860-489-0931, you will be able to leave a message with our answering service and an on-call provider will be contacted immediately. The provider will than contact you ASAP, please be available for a return call!

FINANCIAL ASSISTANCE

Everyone deserves quality healthcare! We are a designated Federally Qualified Healthcare Facility who offers a sliding fee schedule for those who qualify. If you feel you are in need of assistance please inquire within, you will be screened by a financial counselor and appropriate steps will be taken to evaluate your financial needs.

EXCLUDED FROM OUR FINANCIAL ASSISTANCE:

Services rendered offsite provided by other facilities ex. labs, x-rays, specialty care, etc. These charges are NOT the responsibility of CHWCGT.

PRESCRIPTION POLICY

In an effort to better serve our patients, and to manage the large number of medication refill requests that we receive, we ask that our patients help us manage medication refills in the following way:

-Please remember to inform your Provider and Medical Assistant Team about upcoming medication needs at your appointment. Having your provider refill medications on the day of your appointment will allow you to have uninterrupted access to your medications. This will also help prevent many unnecessary telephone calls.

-If you run out of medications in between your appointment, please call your pharmacy first. Sometimes patients have remaining refills at their pharmacy. Also, the pharmacy can contact us electronically without the need for a phone call.

-If you are truly running out of your medications, please contact us at least 5 days in advance so that we can process your refill and prevent you from having to run out completely.

NO SHOW POLICY

There is a very high volume of individuals waiting for appointments at our center. Appointments are in great demand. What makes this situation more difficult is the number of "patients" **who do not keep their scheduled appointments** and do not call in advance to cancel or reschedule an appointment. Due to this, Community Health & Wellness Center is forced to institute a **No Show Policy.**

It is the **Patient's Responsibility** to notify the office at least 24-48 hours in advance of their scheduled appointment to reschedule or cancel so we may offer the time to another patient waiting to be seen.

When a patient misses two scheduled appointments, without notifying the office, the next requested appointment will be stand by (which means no scheduled appointment time will be given and the patient will have to sit and wait for a provider to have an opening in their schedule). **Unfortunately there is no guarantee you will be seen on that day and you may have to return the next day until a provider has an opening in his/her schedule.** In addition, that visit will be brief. We will not delay scheduled patients who show up on time for patients waiting on standby.

By implementing this policy we believe we honor patients who schedule/keep their appointments while accommodating everyone who needs to be seen more efficiently.

LATE POLICY

In an effort to provide optimal care for all patients, please arrive on time for appointments. Patients arriving **later than 10 minutes** may be rescheduled with another provider.

I HAVE READ AND UNDERSTAND THE PRESCRIPTION POLICY, NO SHOW POLICY, AND LATE POLICY AND AS A PATIENT IT IS MY RESPONSIBILITY TO RESPECT THE PATIENT POLICIES OF THE CENTER.

_____ _____

PATIENTS SIGNATURE DATE

Revised 7/2023

Community Health & Wellness
Our Family – Taking Care of Yours

Patient Grievance Policy

A patient, family member, or caretaker shall have the ability to voice a complaint or grievance to the appropriate levels of authority as a part of the patients right to process and in accordance with CHWC's Patient Grievance Protocol. Patients, family members, or caretakers voicing complaints and/or grievances shall not be subjected to retaliation or barriers to care.

A. A patient, family member, or caretaker may register a complaint or grievance to any staff member in person, by telephone, mail, or email within 60 calendar days of the date of the event. A Patient Grievance Form will be completed by the staff member upon notification of a patient's intent to voice a complaint. The staff member will enter the data into CHWC's Feedback Manager software and attach the Patient Grievance Form.
B. Investigation of a complaint will be conducted as expeditiously as the case requires but no later than 30 calendar days after completion of a Patient Grievance Form. If investigation of a complaint requires additional time, the patient will be notified by telephone that the organization may take up to 14 calendar days to continue its investigation.
C. A patient, family member, or caretaker will be notified by telephone upon completion of the investigation of any action taken based on the evidence uncovered during the investigation. CHWC considers a complaint resolved based on the patient's verbal expression of satisfaction with actions taken on his or her behalf.
D. If a complaint is not resolved at this point, the Patient Advocate shall tag the complaint as a grievance and forward to the Medical Director for further investigation or review. The Medical Director shall notify the patient in writing of the decision and the evidence on which the decision was based.
E. If the grievance is still unresolved, the patient may request in writing that the Medical Director submit the grievance to the Board of Directors for review. The Board of Directors shall have 30 days from the receipt of the grievance to make a final determination and deliver the response in writing to the Chief Executive Officer, Medical Director, and patient, family or caregiver.
F. The Review Committee will review on a case by case basis any grievance filed by a patient that has been discharged from service at CHWC and is requesting to reinstate services. There must be sufficient evidence to prove the reason for discharge was an isolated incident or the patient has taken appropriate action to minimize the possibility of a repeat of the action that resulted in discharge from services. If the evidence reviewed is satisfactory to the Review Committee, services may be reinstated.
G. Evaluation of the organization in meeting compliance with this policy is assed every two years by the Chief Executive Officer and the Board of Directors. Evaluation includes:
    a) A quarterly review of the trends in patient grievance by the Continuous Quality Improvement Committee. The CQI Committee will recommend quality initiatives or system changes based on trending.
    b) Quarterly, the Quality Manager will present trended patient grievance data for review by the Medical Director. Any grievance categorized as high priority according to the Patient Grievance Protocol, will be brought to the Medical Director's attention immediately.
    c) A comprehensive bi-annual summary of patient grievance data and trending will go to the Board of Directors for review.

Patient Signature:_____ Date:_____

Patient Printed Name:_____

Community Health & Wellness
Our Family – Taking Care of Yours

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I _____, _____, _____ authorize
PLEASE PRINT – Name of Patient | Date of Birth | Phone Number

☐ **To RELEASE the following information to:**
PLEASE PRINT – Name of Medical Facility or Agency
Address

☐ **To OBTAIN the following information from:**
PLEASE PRINT – Name of Medical Facility or Agency
Address

INITIAL next to the information to be disclosed:

Medical		Dental		Behavioral Health		GYN	
Complete Record		Complete Record		Complete Record		Complete Record	
Patient Summary		Patient Summary		Patient Summary		Patient Summary	
Progress Notes		Procedure Notes		Initial Diagnostic Evaluation		Progress Notes	
Physical Exam		X-Rays		Psychiatric Evaluation		Annual Exam	
Lab Results				Treatment Planning		Lab Results	
Diagnostic Imaging Reports				Progress Notes		Diagnostic Imaging Reports	
Immunizations				Discharge Summary		Pap Smear Results	

Dates of treatment: ☐ **All Dates** **"or"** ☐ **Date Range From:** **To:**

Other specific information to be released _____

Any information you do NOT want disclosed? _____

INITIAL next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for:

HIV/AIDS ☐ **Substance Use Disorders** ☐ **Mental Health/Psychiatric Disorders** ☐

This information will be released for the following purpose (any other use is prohibited)

☐ Disability ☐ Legal ☐ Moving out of state ☐ Specialist Care ☐ To obtain Social Security Card
☐ Personal ☐ Transferring to New PCP ☐ Other: _____

- I understand that the records to be released may contain information pertaining to HIV-related, psychiatrics, drugs and or alcohol abuse treatment, and may contain other confidential information. I understand that the confidentiality of such records is protected under State and Federal Law and cannot be disclosed without my authorization unless otherwise provided by law.
- I understand that refusal to grant consent to release information will not jeopardize my right to obtain treatment, payment or eligibility for benefits, except where disclosure is necessary for the treatment.
- I also understand this consent is subject to revocation at any time by signing the **"CANCELLATION/REVOCATION"** section below, except to the extent that action has been taken in reliance thereon. Federal Law provides that once a release is signed for a Probation or Parole it may not be revoked. Federal law may subject to re-disclosure by the recipient and no longer protect the information disclosed by this institution. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- This Authorization shall expire in 180 days after the date appearing below or 180 days after patient's final treatment.

Date:_____ **Signature:**_____ **Relationship:**_____
Patient/Client or Authorized legal representative/Guardian

Date:_____ **Signature:**_____ **Relationship:**_____
Witness

CANCELATION/REVOCATION: _____ **Date:**_____
Signature of Patient/Client/Authorized Legal Representative

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.