

FOMU YA USAJILI WA MGONJWA

MAHALI: RIVERSIDE SAFE HARBOR PEARL STREET SOUTH END CHAMPLAIN ISLANDS GOOD HEALTH WINOOSKI ESSEX

Kama Kituo cha Afya Chenye Sifa Kiserikali, CHC inatakiwa na serikali kuu kukusanya taarifa zifuatazo. **Tafadhali kumbuka kuwa majibu yote ni ya siri.**

DEMOGRAFIA YA MGONJWA (TAFADHALI JAZA FOMU YOTE KWA KALAMU NYEUSI AU BLUU TU)

JINA LA MWISHO **JINA LA KWANZA** **VIFUPISHO VYA KATI** **JINA LILILOCHAGULIWA (KAMA LIPO)**

ANWANI YA MTA A **JII** **JIMBO** **MISIMBO YA POSTA**

ANWANI YA POSTA (KAMA NI TOFAUTI NA ANWANI YA MAHALI)

NAMBA YA HIFAFDHI YA JAMII **TAREHE YA KUZALIWA** **VIWAKILISHI**

SIMU YA MKONONI **SIMU YA KAZINI** **SIMU YA NYUMBANI**

ANWANI YA BARUA PEPE **NJIA UIPENDAYO YA MAWASILIANO**
 SIMU UJUMBE
 BARUA PEPE PORTAL YA MGONJWA

JINSIA YA KISHERIA <input type="checkbox"/> MWANAMKE <input type="checkbox"/> MWANAUME	JINSIA YA SASA <input type="checkbox"/> MWANAMKE <input type="checkbox"/> MWANAUME	UTAMBULISHO WA KIJISHIA <input type="checkbox"/> MWANAMKE <input type="checkbox"/> MWANAUME <input type="checkbox"/> MWANAUME ALIYEBADILI JINSIA (MWANAMKE KUWA MWANAUME) <input type="checkbox"/> MWANAMKE ALIYEBADILI JINSIA (MWANAMUME KUWA MWANAMKE) <input type="checkbox"/> WANAJOITAMBULISHA KWA JINSIA TOFAUTI <input type="checkbox"/> NYINGINE <input type="checkbox"/> UNAAMUA KUTOFICHUA	MUELEKEO WA KINGONO <input type="checkbox"/> ILIYOZOELEKA AU ANAYEVUTIWA NA JINSIA TOFAUTI <input type="checkbox"/> MSAGAJI, MSENJE, AU JINSIA MOJA <input type="checkbox"/> JINSIA MBILI <input type="checkbox"/> KITU KINGINE <input type="checkbox"/> SIJUI <input type="checkbox"/> UNAAMUA KUTOFICHUA
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LUGHA YA MSINGI **JE, UNAHITAJI HUDUMA ZA MKALIMANI?**
 NDIYO HAPANA

HALI YA NDOA <input type="checkbox"/> SIJAOA/SIJAOLEWA <input type="checkbox"/> TUMETENGANA <input type="checkbox"/> NIMEOA/NIMEOLEW <input type="checkbox"/> MJANE <input type="checkbox"/> MTALAKA <input type="checkbox"/> MAHUSIANO YA KISHERIA	JE, WEWE NI MSTAAFU WA JESHI LA MAREKANI? <input type="checkbox"/> NDIYO <input type="checkbox"/> HAPANA	JE, WEWE NI AFISA KILIMO? <input type="checkbox"/> HAPANA <input type="checkbox"/> MHAMIAJI <input type="checkbox"/> WA MSIMU
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HALI YA MAKAZI?
 JE, WEWE HUNA MAKAZI? NDIYO HAPANA
 KAMA HUNA MAKAZI, WEWE NI: UNACHANGIA MAKAZI (UNAISHI NA WATU WENGINE) MAKAZI MTA A YA MAPITO HAYAJULIKANI

JAMII (CHAGUA ZOTE ZINAZOHUSIKA)

MUASIA	MZAWA WA HAWAII AU MKAZI WA VISIWA VYA PASIFIKI	MTU MWEUSI AU MMAREKANI MWENYE ASILI YA AFRIKA	MMAREKANI MWENYE ASILI YA INDIA AU MZAWA WA ALASKA	MTU MWEUPE	NACHAGUA KUTOJIBU
<input type="checkbox"/> MCHINA	<input type="checkbox"/> MZAWA WA HAWAII	<input type="checkbox"/> MTU MWEUSI AU MMAREKANI MWENYE ASILI YA AFRIKA	<input type="checkbox"/> MMAREKANI MWENYE ASILI YA INDIA AU MZAWA WA ALASKA	<input type="checkbox"/> MTU MWEUPE	<input type="checkbox"/> UNAAMUA KUTOFICHUA
<input type="checkbox"/> MVIETNAM	<input type="checkbox"/> MKAZI MWINGINE WA KISIWA CHA PASIFIKI				
<input type="checkbox"/> MUHINDI WA ASIA	<input type="checkbox"/> MGUAMANI AU MCHAMORRO				
<input type="checkbox"/> MKOREA	<input type="checkbox"/> MSAMOA				
<input type="checkbox"/> MFILIPINO					
<input type="checkbox"/> MJAPANI					
<input type="checkbox"/> MUASIA MWINGINE					

KABILA

ASILI YA KILATINO/A, AU KIHISPANIA	HANA ASILI YA KILATINO/A, AU KIHISPANIA	NACHAGUA KUTOJIBU
<input type="checkbox"/> MMEKSIKO <input type="checkbox"/> MAREKIKI WA MEXICO <input type="checkbox"/> MCHIKANO	<input type="checkbox"/> HANA ASILI YA KILATINO/A, AU KIHISPANIA	<input type="checkbox"/> UNAAMUA KUTOFICHUA
<input type="checkbox"/> PUERTO RICAN		
<input type="checkbox"/> MKUBA		
<input type="checkbox"/> ASILI YA KILATINO/A, AU KIHISPANIA		
<input type="checkbox"/> ASILI NYINGINE YA KILATINO/A, AU KIHISPANIA		



DATE REC/ENTERED:
STAFF INITIALS:

PATIENT REGISTRATION FORM

LOCATION: RIVERSIDE SAFE HARBOR PEARL STREET SOUTH END CHAMPLAIN ISLANDS GOOD HEALTH WINOOSKI ESSEX

As a Federally Qualified Health Center, CHC is required by the federal government to collect the following information. **Please note that all responses are confidential.**

PATIENT DEMOGRAPHICS (PLEASE FILL OUT ENTIRE FORM IN BLACK OR BLUE PEN ONLY)						
LAST NAME		FIRST NAME		MIDDLE INITIAL	CHOSEN NAME (IF ANY)	
STREET ADDRESS		CITY		STATE	ZIP CODE	
MAILING ADDRESS (IF DIFFERENT THAN PHYSICAL ADDRESS)						
SOCIAL SECURITY NUMBER			DATE OF BIRTH		PRONOUNS	
CELL PHONE			WORK PHONE		HOME PHONE	
EMAIL ADDRESS				PREFERRED CONTACT METHOD		
				<input type="checkbox"/> PHONE <input type="checkbox"/> TEXT <input type="checkbox"/> EMAIL <input type="checkbox"/> PATIENT PORTAL		
LEGAL SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	CURRENT GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	GENDER IDENTITY <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> TRANSGENDER MALE (FEMALE-TO-MALE) <input type="checkbox"/> TRANSGENDER FEMALE (MALE-TO-FEMALE) <input type="checkbox"/> GENDERQUEER <input type="checkbox"/> OTHER <input type="checkbox"/> CHOOSE NOT TO DISCLOSE			SEXUAL ORIENTATION <input type="checkbox"/> STRAIGHT OR HETEROSEXUAL <input type="checkbox"/> LESBIAN, GAY, OR HOMOSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> CHOOSE NOT TO DISCLOSE	
PRIMARY LANGUAGE			DO YOU NEED INTERPRETER SERVICES?			
			<input type="checkbox"/> YES <input type="checkbox"/> NO			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPERATED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> CIVIL UNION		ARE YOU A U.S. VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU AN AGRICULTURAL WORKER? <input type="checkbox"/> NO <input type="checkbox"/> MIGRANT <input type="checkbox"/> SEASONAL		
HOUSING STATUS ARE YOU HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF HOMELESS, ARE YOU: <input type="checkbox"/> DOUBLING UP (LIVING WITH OTHERS) <input type="checkbox"/> SHELTER <input type="checkbox"/> STREET <input type="checkbox"/> TRANSITIONAL <input type="checkbox"/> UNKNOWN						
RACE (SELECT ALL THAT APPLY)						
ASIAN	NATIVE HAWAIIAN OR PACIFIC ISLANDER		BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> CHINESE <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> KOREAN <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> OTHER ASIAN	<input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN		<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE	<input type="checkbox"/> WHITE	<input type="checkbox"/> CHOOSE NOT TO DISCLOSE
ETHNICITY						
HISPANIC, LATINO/A, OR SPANISH ORIGIN			NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN		CHOOSE NOT TO DISCLOSE	
<input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> HISPANIC, LATINO/A, OR SPANISH ORIGIN <input type="checkbox"/> ANOTHER HISPANIC, LATINO/A, AND SPANISH ORIGIN			<input type="checkbox"/> NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN		<input type="checkbox"/> CHOOSE NOT TO DISCLOSE	

Jina la Mgonjwa:

Tarehe ya Kuzaliwa:

TAARIFA YA KIFEDHA: TAFADHALI ZUNGUSHIA UKUBWA UNAOFAA WA FAMILIA NA KIWANGO KINACHOHUSIANA NA MAPATO YA KAYA KWENYE JEDWALI HAPO CHINI. *MAJIBU YOTE NI SIRI.*

MIONGOZO YA UMASIKINI YA SERIKALI KUU YA 2024				
UKUBWA WA FAMILI	0-100% KIWANGO CHA UMASIKINI CHA SERIKALI KUU	101-150% KIWANGO CHA UMASIKINI CHA SERIKALI KUU	151-200% KIWANGO CHA UMASIKINI CHA SERIKALI KUU	ZAIDI YA 200% KIWANGO CHA UMASIKINI CHA SERIKALI KUU
KIWANGO CHA MAPATO YA KAYA YA MWAKA KULINGANA NA UKUBWA WA FAMILIA				
1	\$0 HADI \$15,060	\$15,061 HADI \$22,590	\$22,591 HADI \$30,120	\$30,121 & ZAIDI
2	\$0 HADI \$20,440	\$20,441 HADI \$30,6060	\$30,661 HADI \$40,880	\$40,881 & ZAIDI
3	\$0 HADI \$25,820	\$25,821 HADI \$38,730	\$38,731 HADI \$51,640	\$51,641 & ZAIDI
4	\$0 HADI \$31,200	\$31,201 HADI \$46,800	\$46,801 HADI \$62,400	\$62,401 & ZAIDI
5	\$0 HADI \$36,580	\$36,581 HADI \$54,870	\$54,871 HADI \$73,160	\$73,161 & ZAIDI
6	\$0 HADI \$41,960	\$41,961 HADI \$62,940	\$62,941 HADI \$83,920	\$83,921 & ZAIDI
7	\$0 HADI \$47,340	\$47,341 HADI \$71,010	\$71,011 HADI \$94,680	\$94,681 & ZAIDI
8	\$0 HADI \$52,720	\$52,721 HADI \$79,080	\$79,081 HADI \$105,440	\$105,441 & ZAIDI
9	\$0 HADI \$58,100	\$58,101 HADI \$87,150	\$87,151 HADI \$116,200	\$116,201 & ZAIDI
10	\$0 HADI \$63,480	\$63,481 HADI \$95,220	\$95,221 HADI \$126,960	\$126,961 & ZAIDI
*	*ONGEZA \$5,380 KWA KILA MWANAFAMILIA WA ZIADA.	*ONGEZA \$8,070 KWA KILA MWANAFAMILIA WA ZIADA.	*ONGEZA \$10,760 KWA KILA MWANAFAMILIA WA ZIADA.	

TAARIFA ZA BIMA YA MENO

- Kwa sasa nina bima ya meno.
 Kwa sasa SINA bima ya meno.
 Ningependa kuomba kiwango cha punguzo la ada.

JINA LA BIMA YA MENO:

SERA/NAMBA YA KITAMBURISHO:

JINA LA MMILIKI WA SERA:

TAARIFA ZA BIMA YA MENO YA PILI:

JINA LA BIMA YA MENO:

SERA/NAMBA YA KITAMBURISHO:

JINA LA MMILIKI WA SERA:

TAARIFA YA BIMA YA MATIBABU

- Kwa sasa nina bima ya matibabu.
 Kwa sasa SINA bima ya matibabu.
 Ningependa kuomba kiwango cha punguzo la ada.

JINA LA BIMA YA MATIBABU:

SERA/NAMBA YA KITAMBURISHO:

JINA LA MMILIKI WA SERA:

TAARIFA YA BIMA YA PILI YA MATIBABU:

JINA LA BIMA YA MATIBABU:

SERA/NAMBA YA KITAMBURISHO:

JINA LA MMILIKI WA SERA:

DUKA LA DAWA UNALOPENDELEA

JINA LA DUKA LA DAWA

ENEO LA DUKA LA DAWA

MAWASILIANO YA DHARURA

JINA

UHUSIANO

NAMBA YA SIMU

TAARIFA ZA MTU ANAYEWAJIBIKA (MGONJWA YEYOTE MWENYE UMRI CHINI YA MIAKA 18 LAZIMA AWE NA MTU ANAYEWAJIBIKA)

- MZAZI MLEZI
 MLEZI (UTHIBITISHO WA HALI YA KISHERIA INAYOTAKIWA KWA AJILI YA MATIBABU CHC)

JINA LA MWISHO
(KAMA LIPO)

JINA LA KWANZA

VIFUPISHO VYA KATI

JINA LILILOCHAGULIWA

ANWANI YA MTA A

JII

JIMBO

MISIMBO YA POSTA

TAREHE YA KUZALIWA

NAMBA YA SIMU

Patient Name:

Date of Birth:

FINANCIAL INFORMATION: PLEASE CIRCLE THE APPROPRIATE FAMILY SIZE AND CORRESPONDING HOUSEHOLD INCOME RANGE ON THE TABLE BELOW. ALL RESPONSES ARE CONFIDENTIAL.

2024 FEDERAL POVERTY GUIDELINES				
FAMILY SIZE	0-100% FEDERAL POVERTY LEVEL	101-150% FEDERAL POVERTY LEVEL	151-200% FEDERAL POVERTY LEVEL	OVER 200% FEDERAL POVERTY LEVEL
HOUSEHOLD ANNUAL INCOME RANGE BASED ON FAMILY SIZE				
1	\$0 TO \$15,060	\$15,061 TO \$22,590	\$22,591 TO \$30,120	\$30,121 & OVER
2	\$0 TO \$20,440	\$20,441 TO \$30,6060	\$30,661 TO \$40,880	\$40,881 & OVER
3	\$0 TO \$25,820	\$25,821 TO \$38,730	\$38,731 TO \$51,640	\$51,641 & OVER
4	\$0 TO \$31,200	\$31,201 TO \$46,800	\$46,801 TO \$62,400	\$62,401 & OVER
5	\$0 TO \$36,580	\$36,581 TO \$54,870	\$54,871 TO \$73,160	\$73,161 & OVER
6	\$0 TO \$41,960	\$41,961 TO \$62,940	\$62,941 TO \$83,920	\$83,921 & OVER
7	\$0 TO \$47,340	\$47,341 TO \$71,010	\$71,011 TO \$94,680	\$94,681 & OVER
8	\$0 TO \$52,720	\$52,721 TO \$79,080	\$79,081 TO \$105,440	\$105,441 & OVER
9	\$0 TO \$58,100	\$58,101 TO \$87,150	\$87,151 TO \$116,200	\$116,201 & OVER
10	\$0 TO \$63,480	\$63,481 TO \$95,220	\$95,221 TO \$126,960	\$126,961 & OVER
*	<i>*ADD \$5,380 PER EACH ADDITIONAL FAMILY MEMBER.</i>	<i>*ADD \$8,070 PER EACH ADDITIONAL FAMILY MEMBER.</i>	<i>*ADD \$10,760 PER EACH ADDITIONAL FAMILY MEMBER</i>	

DENTAL INSURANCE INFORMATION

- I currently have dental insurance.
- I currently DO NOT have dental insurance.
- I would like to apply for the sliding-fee scale.

DENTAL INSURANCE NAME:

POLICY/ID NUMBER:

POLICY HOLDER NAME:

SECONDARY DENTAL INSURANCE INFORMATION:

DENTAL INSURANCE NAME:

POLICY/ID NUMBER:

POLICY HOLDER NAME:

MEDICAL INSURANCE INFORMATION

- I currently have medical insurance.
- I currently DO NOT have medical insurance.
- I would like to apply for the sliding-fee scale.

MEDICAL INSURANCE NAME:

POLICY/ID NUMBER:

POLICY HOLDER NAME:

SECONDARY MEDICAL INSURANCE INFORMATION:

MEDICAL INSURANCE NAME:

POLICY/ID NUMBER:

POLICY HOLDER NAME:

PREFERRED PHARMACY

PHARMACY NAME

PHARMACY LOCATION

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (ANY PATIENT UNDER 18 YEARS OLD MUST HAVE A RESPONSIBLE PARTY)

- CUSTODIAL PARENT
- GUARDIAN (PROOF OF LEGAL STATUS REQUIRED FOR TREATMENT AT CHC)

LAST NAME	FIRST NAME	MIDDLE INITIAL	CHOSEN NAME (IF ANY)

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	PHONE NUMBER

Idhini ya Matibabu na Idhini ya Kutoa Taarifa za Afya

I. Idhini ya Matibabu

Ninatoa idhini yangu ya matibabu kwa ajili yangu mwenyewe, au kwa ajili ya mgonjwa aliyetajwa (ambaye mimi ni mzazi au mlezi halali ambaye ana haki ya kukubali matibabu ya mgonjwa aliyetajwa) kwa Vituo vya Afya vya Jamii (CHC). Matibabu yanaweza kujumuisha uchunguzi wa afya, utambuzi, matibabu, huduma za meno, huduma za kijamii, afya ya akili au uchunguzi wa matumivi ya madawa ya kulevya na pombe, tathmini, utambuzi na matibabu, na huduma za afya ya akili.

II. Idhini ya kutoa taarifa za afya

Ninakubali CHC kutumia kumbukumbu zangu (au za mgonjwa aliyetajwa ambaye mimi ni mzazi au mlezi wa kisheria) za matibabu, meno, matumizi ya madawa ya kulevya na pombe, afya ya akili, ugonjwa wa akili na matibabu mengine ("taarifa za afya") ndani ya CHC na kuzitoa kwa watu au mashirika nje ya CHC kwa madhumuni yafuatayo:

A. Matumizi ya taarifa za afya ya CHC kwa ajili ya matibabu, malipo, na shughuli za huduma za afya:

- Kutoa matibabu kunakotekelezwa na wafanyakazi wa CHC.
- Uendeshaji wa shughuli za huduma za afya, ikiwemo ukaguzi na/au mafunzo ya fedha au udhibi wa ubora.
- Iandikie bili kampuni yako ya bima moja kwa moja
- Malipo ya huduma zinazotolewa na CHC. CHC imeidhinishwa kupata malipo ya huduma za afya na inaweza kuwasilisha taarifa za afya kwenye kampuni za bima, bima ya fidia kwa wafanyakazi au mashirika mengine ambayo hulipia huduma za afya, au taarifa nyingine mpya za bima kwenye faili la CHC.

B. Utoaji wa taarifa za afya kwa watu au mashirika nje ya CHC kwa ajili ya matibabu:

- CHC imeidhinishwa kutoa taarifa zote za afya kwa watoa huduma wengine wa afya au mashirika ambayo yanashiriki kukupatia huduma. Hii ni pamoja na taarifa za afya za zamani kutoka nje ya mashirika. (Utoaji wa mwisho wa taarifa lazima uwasilishwe kwa familia zote, marafiki, au watu wengine ambao ungetaka wapate taarifa zako za matibabu.)



- RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
- CHAMPLAIN ISLANDS • SOUTH END • GOOD HEALTH • WINOOSKI • ESSEX •

Consent for Treatment and Consent to Release Health Information

I. Consent for Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers (CHC). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Consent to release health information:

I consent to the use within CHC and the disclosure to persons or organizations outside of CHC of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by CHC for the following purposes:

A. Use of health information by or for CHC for treatment, payment, and health care operations:

- Providing treatment by CHC staff.
- Conducting health care operations, including financial or quality assurance audits and/ or training.
- Bill your insurance company directly
- Payment for services provided by CHC. CHC is authorized to obtain payment for health care services and can provide health records to insurance companies, workers compensation insurers or other agencies that pay for health services, or other updated insurance information on file with CHC.

B. Disclosure of health information to persons or organizations outside of CHC for treatment purposes:

- CHC is authorized to provide all health information to other health providers or agencies who participate in your care. This includes past medical records from outside organizations. (An Individual release of information must be submitted for all family, friends, or other persons that you wish to access your Medical Record information.)

III. Ugawaji wa faida

Ninairuhusu CHC kiandikia bili na kupokea malipo moja kwa moja kutoka Medicaid/Medicare au watoa huduma wengine wa bima kwa huduma nilizopewa.

Kwa hiyo ninaipatia CHC malipo yote kutoka Medicaid, Medicare, au sera yoyote ya bima ya afya kwa huduma za afya, nilizopewa na CHC.

Ninaelewa kwamba nina wajibu wa kulipa kiasi chochote ambacho hakijaliwa kinachotokana na huduma nilizopatiwa na CHC.

Ninaelewa kwamba, kwa ufahamu wangu wote, taarifa za kidemografia nilizotoa ni za kweli na sahihi.

Nakala ya matarajio ya malipo ya CHC inapatikana utakapoiomba.

IV. Ukiukaji na mipaka ya idhini hii:

- A.** Ninaelewa kwamba nina haki ya kufuta idhini hii wakati wowote kwa maandishi, kufuta idhini hii hakutaathiri hatua zozote zilizochukuliwa na CHC kwa kutegemea idhini hii kabla ya kufutwa. Ikiwa haijafutwa hapo awali, idhini hii itaisha tarehe ifuatayo: _____ . Ikiwa hakuna kilichobainishwa, idhini hii itaisha miaka mitatu baada ya tarehe ya mwisho kupatiwa huduma.
- B.** Ninaelewa kwamba ninaweza kuomba kuweka mipaka ya matumizi au utoaji wa taarifa zangu za afya kwa madhumuni yaliyoelezewa katika idhini hii na kwamba CHC inaweza kukubali au kukataa ombi hilo. Pia ninaelewa kwamba isipokuwa kwa mipaka hiyo ya matumizi au utoaji wa taarifa za afya ambayo CHC inaikubali, CHC haitaweza kukupa huduma (au mgonjwa aliyetajwa) bila idhini hii iliyosainiwa.
- C.** Nimeisoma Idhini hii ya Matibabu na Idhini ya Kutoa Taarifa za Afya, na ninaelewa na kujua maudhui ya idhini hii.

Ninathibitisha kuwa huduma za matumizi ya lugha nilipatiwa kabla ya kusaini fomu hii ya Idhini ya Matibabu na Idhini ya Kutoa Taarifa za Afya.

Kwa hivyo ninakiri kwamba nimepewa nakala ya Notisi ya Matendo ya Faragha na ninaelewa kuwa CHC itatumia maelezo yangu ya afya yanayolindwa kwa mujibu wa sheria ya faragha.

Jina la Mgonjwa: _____ Tarehe ya Kuzaliwa _____
 Sahihi ya Mgonjwa: _____ Tarehe: _____
 Mzazi/Mlezi: _____
 Sahihi ya Mzazi/Mlezi: _____ Tarehe: _____

III. Assignment of Benefits

I authorize CHC to bill and receive payment directly from Medicaid /Medicare or any other insurance carrier for services provided to me.

I hereby assign to CHC all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to me by CHC.

I understand I am responsible for any unpaid balances incurred because of my care at CHC.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct.

A copy of the CHC payment expectations is available at your request.

IV. Termination and restrictions of this consent:

- A. I understand that I have the right to cancel this consent at any time in writing, cancelling this consent will not affect any actions taken by CHC in reliance of this consent before it was cancelled. If not previously cancelled, this consent will end on the following date: _____ . If none is indicated, this consent will end three years after the last date of services to me.
- B. I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHC may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHC will not be able to provide services to you (or the named patient) without this signed consent.
- C. I have read this Consent for Treatment & Consent to Release of Health Information, and I understand and knowingly consent to its content.

I confirm that language access services were provided to me before I signed this Consent for Treatment & Consent to Release of Health Information form.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand CHC will use my protected health information in accordance with privacy law.

REQUIRED

Name of Patient: _____ Date of Birth _____
 Patient Signature: _____ Date: _____
 Parent/Guardian: _____
 Parent/Guardian Signature: _____ Date: _____

Fomu ya Historia ya Matibabu/Meno

Jina la Mtoto: _____ Tarehe ya kuzaliwa: _____

Shule Anayosoma Mtoto: _____ Tarehe ya leo: _____

Historia ya Matibabu

Tafadhali chagua tatizo lolote la afya ambalo mtoto wako analo:

- | | | |
|---|--|--|
| <input type="checkbox"/> Pumu | <input type="checkbox"/> Mizio | <input type="checkbox"/> Upungufu wa damu |
| <input type="checkbox"/> Saratani | <input type="checkbox"/> Tatizo la Moyo la Kuzaliwa | <input type="checkbox"/> Homa Baridi Yabisi |
| <input type="checkbox"/> Homa ya Manjano | <input type="checkbox"/> Mshtuko/Kifafa | <input type="checkbox"/> Ulemavu wa Viungo/Ulemavu |
| <input type="checkbox"/> VVU/UKIMWI | <input type="checkbox"/> Kifua Kikuu | <input type="checkbox"/> Kuugua kwa Moyo |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kutokwa Damu Kusiko kwa Kawaida | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Kisukari | <input type="checkbox"/> Tatizo la Uwazi katika Mfupa | <input type="checkbox"/> Ugonjwa wa Akili wa Watoto wa Spektra |
| <input type="checkbox"/> Nyingine (tafadhali bainisha): _____ | | |

Taarifa Zingine za Afya

Tafadhali chagua tatizo lolote la afya ambalo mtoto wako analo:

- Mtoto wangu anavuta bidhaa za tumbaku
 - Kama ndiyo, kiasi gani? _____
 - Je, yuko radhi kuacha? _____
- Mtoto wangu anatumia madawa ya kuburudisha
- Mtoto wangu anakunywa pombe
- Mtoto wangu ni mjamzito au inawezekana ni mjamzito
- Mtoto wangu ana vidonda mdomoni mwake jambo linalofanya iwe tatizo
- Mtoto wangu amekabiliwa na matatizo katika matibabu yake ya awali ya meno
- Mtoto wangu alikuwa ameambiwa kwamba anahitaji viua vijasumu kabla ya matibabu ya meno
- Mtoto wangu ana changamoto ya usalama nyumbani au anapokuwa na marafiki
- Je, kuna suala jingine la meno au la afya ambalo ungependa tulijadili leo?
 - Kama ndiyo, tafadhali elezea: _____

Je, mtoto wao ana mzio wa au alipata athari mbaya kutokana na bidhaa zozote kati ya zifuatazo:

- | | |
|---|---|
| <input type="checkbox"/> Dawa za ganzi | <input type="checkbox"/> Kodeini au dawa zingine za usingizi |
| <input type="checkbox"/> Mpira | <input type="checkbox"/> Penicillin au dawa zingine za viuadudu |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Vitulizo au vidonge vya usingizi |
| <input type="checkbox"/> Nyingine (tafadhali bainisha): _____ | <input type="checkbox"/> Madini ya Joto |

Tafadhali orodhesha dawa zote ambazo mwanafunzi wako anazitumia (tafadhali jumuisha dawa alizoandikiwa na daktari na asizoandikiwa na daktari):

Medical/Dental History Form

Child's Name: _____ Date of birth: _____

School Child Attends: _____ Today's date: _____

Medical History

Please check any of the following that apply to your child:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Handicap/Disability |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Autism Spectrum |
| <input type="checkbox"/> Other (please describe): _____ | | |

Other Health Information

Please check any of the following that apply to your child:

- My child smokes tobacco products
 - If yes, how much? _____
 - Are they interested in quitting? _____
- My child uses recreational drugs
- My child consumes alcohol
- My child is pregnant or possibly pregnant
- My child has sores in their mouth that are concerning
- My child has had trouble with previous dental work
- My child has been told they need antibiotics prior to past dental work
- My child has safety concerns at home or with friends
- Are there other dental or health concerns you would like to discuss today?
 - If yes, please describe:

Is your child allergic to or had a bad reaction to any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin or other antibiotics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sedatives or sleeping pills |
| <input type="checkbox"/> Other (please describe): _____ | <input type="checkbox"/> Iodine |

Please list all the medications your student is taking (please include prescription and non-prescription drugs): _____

Tafadhali saina hapo chini ili kuhakikisha huduma sahihi ya meno/matibabu kwa mtoto wako. Kadri ya upeo wa ufahamu wangu, maswali yaliyo kwenye fomu hii yamejibiwa kwa usahihi. Ninaelewa kwamba kutoa taarifa isiyo sahihi inaweza kuwa hatari kwa afya ya mtoto wangu. Ni jukumu langu kuitaarifu Ofisi ya mtoa huduma ya afya kuhusu mabadiliko yoyote katika historia ya matibabu ya mtoto wangu.

Sahihi ya Mzazi/Mlezi: _____ Tarehe: _____

Sahihi ya mtu anayejaza fomu hii kama sio mzazi/mlezi: _____

Simu ya Mawasiliano: _____

Idhini ya Utoaji wa Huduma

Ninatoa idhini kwa CHC – Kitua cha Meno cha Shule ya:

- Kupanga ratiba na kumtibu mtoto wangu kwa mahitaji ya kinga na urejeshaji wa meno
- Kupanga ratiba na kumtibu mtoto wangu kwa mahitaji ya meno ninapokuwa nimetoa ruhusa tu (kwa mdomo au maandishi)
- Kupanga na kumtibu mtoto wangu kwa mahitaji ya meno pale ninapokuwepo tu (isipokuwa katika huduma za dharura za matibabu, meno, au afya ya akili)

Mawasiliano ya Dharura/Mabadiliko katika Hali ya Afya au Malezi

Ninakubali zaidi kwamba nitawajulisha mara moja wafanyikazi wa CHC kwa maandishi kuhusu:

- Mabadiliko yoyote katika afya ya mwili na ya meno ya mtoto wangu na
- Mabadiliko yoyote malezi ya mtoto wangu ambayo yanaathiri uwezo wangu wa kutoa idhini hii kwa niaba ya mtoto wangu.

Makubaliano kuhusu usafiri wa kwenda na kurudi kutoka CHC – Kituo cha Meno cha Shule

Jimbo la Vermont limeingia makubaliano na Wakala Maalum wa Huduma za Usafirishaji (SSTA) kutoa huduma za usafiri kwa wanafunzi wenye sifa ya kupata Medicaid kwenda na kurudi kutoka shule za Burlington na Vituo vya Meno vya CHC.

Kama mtoto wangu anahitaji usafiri kama ilivyoonyeshwa hapo chini, **ninawaruhusu CHC kuratibu usafiri wa SSTA kumchukua mtoto wangu kwenda na kurudi shuleni kwake kwa ajili ya huduma za meno, bila malipo kutoka kwangu.** CHC inaweza kutoa taarifa kuhusu mahitaji ya mtoto wangu kwa madhumuni ya usafiri na malipo.

Tafadhali kumbuka kwamba SSTA inaweza kutafuta malipo kutoka Medicaid kwa ajili ya huduma hizo za usafiri.

Kama mtoto wangu ataonekana mwishoni mwa siku ya shule, mtoto wangu:

- Atasafirishwa kurudi nyumbani kwa kutumia SSTA.
- Ana angalau umri wa miaka 16 na anaweza kuondoka na kutembea kurudi nyumbani kwa kujichunga wao wenyewe.

Mimi (jina la mzazi au mlezi) _____ nimesoma nyenzo za hapo juu na kuelewa maana yake. Sahihi yangu ni uthibitisho kwamba nimepitia fomu hii, nimeelewa taarifa na idhini ya hatua zote zilizobainishwa hapo juu. Pia sahihi yangu inathibitisha usahihi wa taarifa iliyotolewa kwenye fomu hii.

Sahihi ya Mzazi/Mlezi: _____ Tarehe: _____

Sahihi ya mtu anayejaza fomu hii kama sio mzazi/mlezi: _____

Simu ya Mawasiliano: _____

READ ONLY

Please sign below to ensure proper dental/ health care for your child. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to notify the health care provider's office of any changes in my child's medical history.

Parent/Guardian Signature: _____ Date: _____

Signature of person completing form if not parent/guardian: _____

Contact Phone: _____

Consent to the Provision of Services

I authorize CHC – School-Based Dental Center to:

- Schedule and treat my child for preventative and restorative dental needs
- Only schedule and treat my child for dental needs when I have given permission (verbal or written)
- Only schedule and treat my child for dental needs when I am present (except in the care of a medical, dental, or mental health emergency)

Emergency Contact/Changes in Health Status or Custody

I further agree that I will promptly inform CHC staff in writing of:

- Any change in my child's physical or dental health and
- Any change in the custody or guardianship of my child which affects my ability to provide this consent on behalf of my child.

Agreement Concerning Transportation to and from CHC – School-Based Dental Center

The State of Vermont has contracted with Special Services Transportation Agency (SSTA) to provide transportation services for Medicaid eligible students to and from Burlington's schools and the CHC Dental Centers.

If my child needs transportation as indicated below, **I consent to having CHC schedule SSTA transportation take my child to and from their school for dental services, at no cost to me.** CHC may disclose information about my children's need for transportation and payment purposes.

Please note that SSTA may seek reimbursement from Medicaid for such transportation services.

If my child is seen at the end of the school day, my child:

- Should be transported home via SSTA.
- Is at least 16 years of age and may leave and walk home under their own supervision.

I (parent or guardian name) _____ have read the above material and understand its meaning. My signature is an acknowledgment that I have reviewed this form, understand the information and consent to all the actions described above. My signature also attests to the accuracy of the information provided on this form.

Parent/Guardian Signature: _____ Date: _____

Signature of person completing form if not parent/guardian: _____

Contact Phone: _____



Student's Name: _____ Student's Date of Birth: _____
(Last) (First) (MI)

Important Information About Silver Diamine Fluoride

Silver Diamine Fluoride (SDF): Is an antibiotic liquid. We apply it to teeth to help STOP tooth decay. SDF causes the decay to turn black; ONLY THE DECAYED area will turn black. Healthy tooth structure will not be affected. In some cases the tooth may not require any additional dental treatment.

Benefits of using SDF:

- Patient does not need to get a shot, no numbing medicine needed! Application of SDF is painless as it is brushed onto the tooth surface just like regular fluoride!
- Painless and easy to apply!

Disadvantages of SDF:

- Most effective with multiple applications.
- The teeth treated may still need routine dental treatment in the future (fillings, extraction) depending on the extent of decay.

I am the Parent/Guardian of:

Name _____ DOB _____.

I consent to the use of SDF as prescribed by the CHC provider:

Yes _____ No _____

My signature below is an acknowledgement that I have reviewed this form, understand the information, and consent to all of the actions listed above.

Signature of Parent/Guardian _____ Date _____