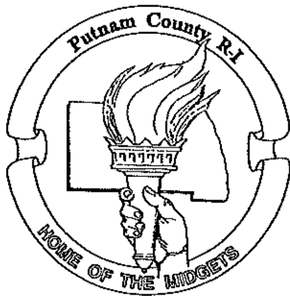

Putnam County R-I Schools

Dr. Heath Halley Ed.D. Superintendent
803 S. 20th • Unionville, MO 63565 • Phone 660-947-3361 • Fax 660-947-2912
www.putnamcountyr1.net

Barb Hodges	*Tiffani Klinginsmith*	*Andrew Garber*	*Donna Altiser*	*Monica Casady*
Instructional Leader	High School Principal	Middle School Principal	Elementary Principal	Special Education Director
803 S. 20th	803 S. 20th	802 S. 18th	801 S. 20th	803 S. 20th

August 26, 2022

Dear Parents/Guardians:

I have some exciting news! Our school is partnering with Northeast Missouri Health Council to bring a Mobile Medical Program to our school! Essentially, this is a doctor's office on wheels. It is much like the Mobile Dental Unit that comes twice a year that you may have seen sitting outside the elementary doors. Providers are able to see students for anything they would normally see them in the office for such as well-child checkups, follow-up appointments, sick visits, sports physicals, immunizations, etc. And the best part is you don't have to worry about missing work or driving to Kirksville and the students miss much less class time! Parents/Guardians are not required to be in attendance. The provider will send home a detailed summary of the visit with the student and/or call the parent/guardian to summarize once the visit is complete.

The Mobile Medical Program will accept most major health insurances and MO Healthnet, Missouri Care, United Healthcare Community Plan, and Home State Health Plan. If the student does not have any health insurance, NMHC will work with parents/guardians to obtain coverage and/or NMHC's sliding fee program. The sliding fee program is income based and provides discounts for services.

If you would like your child to have the opportunity to be seen on the Mobile Medical Unit, please complete the packet and return it to school by **Friday, September 2nd. The Mobile Medical Unit will be visitng our school on September 22, 2022.** If you already filled out a packet last spring for the Medical Unit, you do not have to fill out another one. If you have any questions, please do not hesitate to call me at 660-947-3361, ext. 319 or email me at sgillum@putnamcountyr1.net.

Sincerely,

Stephanie Gillum

Stephanie Gillum
School Nurse

" Creating Opportunities Through Quality Education "

NORTHEAST MISSOURI
HEALTH COUNCIL
Partners for a Lifetime of health

MOBILE MEDICAL PROGRAM

The Northeast Missouri Health Council (NMHC) is excited to partner with your school to provide medical services at school during normal school hours.

The Mobile Medical Program will accept Home State, UHC Community Plan, and Healthy Blue. There is no cost or financial requirement to the parent if the student is covered by one of these plans. If the child is uninsured, NMHC staff will work with the parent/guardian to verify eligibility and/or apply for appropriate coverage, if applicable.

The attached packet must be filled out and returned to the school nurse before the child can be scheduled on the mobile unit. The consent form in this packet must be signed by a parent or guardian.

MOBILE MEDICAL PROGRAM is scheduled to be at your school during the school year. Appointments are limited, so please return completed forms to the school nurse ASAP as priority is given to students who return the completed paperwork promptly, as well as those who have the greatest needs. If you have questions, please contact your school nurse or the school office. We look forward to working with you and your child!

Northeast Family Health
1416 Crown Drive
Kirksville, MO 63501
660.627.4493

Edina Family Health
104 E. Jackson
Edina, Mo 63537
660.397.3517

Macon Family Health
209 N. Missouri St.
Macon, MO 63552
660.395.5045

Northeast Family Health
52334 Business HWY 5
Milan, MO 63556
660.265.1042

Regarding precautions for COVID-19: *Safety for the staff and students is NMHC's main priority. We will be taking every precaution possible to ensure a safe and sterile environment for the children who receive services on the mobile unit.*

Please return completed packets to your school ASAP!

Consent to Treat/Mobile Medical Unit/Parent Not Present

______________________________ ____/____/____
Child's Name DOB

____
Child's School

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council while my child is on the MOBILE MEDICAL UNIT.

Please list any health issues the child may be having AND/OR list any issues you would like your child seen/evaluated for: ____

____.

Please list any specific limitations for this authorization: ______________________

____.

______________________________ ______________________
PRINTED Parent/Guardian Name Relationship to Patient

______________________________ ____/____/____
Parent/Guardian Signature DATE

NORTHEAST MISSOURI
HEALTH COUNCIL
"Partners for a Lifetime of health"

PATIENT INFORMATION

Date____/____/____	School:	
Grade:	Teacher:	
CHILD'S INFORMATION		
FNAME:	M.I.	LNAME:
DOB: ____/____/____	Age:	Gender:
Mother's Maiden Name:		Preferred Language:
Child's Primary Doctor:		Child's Primary Dentist:
Does child have prescription drug coverage? Yes or No		Preferred Pharmacy:
Is the child homeless or displaced? Yes or No		Child's race and ethnicity:
PARENT/GUARDIAN CONTACT INFORMATION		
Parent/Guardian Name:		Parent/Guardian DOB: ____/____/____
Address:		Parent/Guardian SS#: ____-____-____
City/State/Zip:		
Primary Phone #: ( ) ____-____ ***is this a cell # Y or N***		Alternate Phone #: ( ) ____-____
EMERGENCY CONTACT INFORMATION		
Name of Emergency Contact (other than parent):		Relationship to Child:
Phone # of Emergency Contact: ( ) ____-____		
INSURANCE INFORMATION		
Is Child Covered by Missouri MEDICAID/Mo HealthNet (including Healthy Blue, United Healthcare Community Plan, and Home State Health Plan?) **YES or NO**		
If **YES**, what is the MEDICAID #/DCN?		
Circle type if known: Healthy Blue United Healthcare Community Plan Home State Health Plan		
Is child covered by OTHER MEDICAL INS? YES or NO ***(fill out as much information as known about other insurance below)***		
If YES, what is the type/name?		
Policy #:	Group #:	
Address to mail claims:		
Policy Holder Name:		
Policy Holder DOB: ____/____/____		Policy Holder SS#: ____-____-____
Policy Holder Relationship to Child:		

NE Pediatrics - NMHC

Date: ______/______/______

Patient Name:____

DOB: ______/______/______

Family History

How many siblings? ______Brothers _____Sisters In good health? ____Yes ___No

Has this child or any blood relative had any of the following? ***<u>**Please circle all that apply</u>***

Who (Paternal or Maternal)? Example: Allergies: Maternal Grandmother

ADD/ADHD	______________________	Genetic Disorder	________________
Allergies	______________________	High Cholesterol	________________
Birth Defects	______________________	High Blood Pressure	________________
Asthma	______________________	Learning Disabilities	________________
Cancer	______________________	Migraines	________________
Heart Disease	______________________	Scoliosis	________________
Depression	______________________	Seizure Disorder	________________
Developmental Delays	______________________	Thyroid Disease	________________
Diabetes	______________________	Other	________________

Past Medical History

Has the patient ever been diagnosed with any of the following?

_____Anemia _____Chicken Pox _____Constipation _____Eczema _____GERD/Reflux

_____Headaches _____Hearing Problems _____Heart Murmur _____Prematurity _____Ear Infections

_____Respiratory Problems Other____

____

Past Surgical History

Has the patient ever had any of the following surgeries? If so, when?

_____Appendectomy year______ _____Adenoidectomy year_______ _____Hernia Repair year ____

_____Tubes in Ears year______ _____Dental Surgery year_______ _____Tonsillectomy year ____

_____Other Surgery: ____

HIPAA & INS/TX AUTH – Mobile Dental Unit

NORTHEAST MISSOURI HEALTH COUNCIL
Partners for a lifetime of health

PATIENT NAME____ **DOB** ______/______/______
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used for: **treatment, payment, and healthcare operations.** NMHC'S NOTICE of PRIVACY PRACTICES is posted in each clinic reception area, is available from any front desk associate, and can be viewed online at nemohealthcouncil.com. I understand Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time. My signature below indicates I have read and understand NMHC's Notice of Privacy Practices.

Patient/Guardian Signature____________________________________ **Date** ______/______/______

ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

Patient/Guardian Signature____________________________________ **Date** ______/______/______

1. Circle the NUMBER of people in your household.
2. Follow that number across to the column closest to your household income and circle that LETTER.
3. Anyone between letters A-E may be eligible for our SLIDE program with appropriate income documentation. Category F is overqualified for SLIDE.

Household Size	A	B	C	D	E	F
1	0 - 13,590	13,591 - 16,988	16,989 - 20,385	20,386 - 23,783	23,784 - 27,179	27,180 & above
2	0 - 18,310	18,311 - 22,888	22,889 - 27,465	27,466 - 32,043	32,044 - 36,619	36,620 & above
3	0 - 23,030	23,031 - 28,788	28,789 - 34,545	34,546 - 40,303	40,304 - 46,059	46,060 & above
4	0 - 27,750	27,751 - 34,688	34,689 - 41,625	41,626 - 48,563	48,564 - 55,499	55,500 & above
5	0 - 32,470	32,471 - 40,588	40,589 - 48,705	48,706 - 56,823	56,824 - 64,939	64,940 & above
6	0 - 37,190	37,191 - 46,488	46,489 - 55,785	55,786 - 65,083	65,084 - 74,379	74,380 & above
7	0 - 41,910	41,911 - 52,388	52,389 - 62,865	62,866 - 73,343	73,344 - 83,819	83,820 & above
8	0 - 46,630	46,631 - 58,288	58,289 - 69,945	69,946 - 81,603	81,604 - 93,259	93,260 & above
	add $4,720 per	*add $5,900 per*	*add $7,080 per*	*add $8,260 per*	*add $9,440 per*	

**For families with more than 8 members add the appropriate figure noted in each column per additional member.*

As a Federally Qualified Health Center (FQHC), NMHC is required to request socioeconomic data on our patients. Please circle your **household size** (NUMBER) and the approximate **annual income category** (LETTER) on the chart below, such as 1A or 4D, etc. NMHC, Inc., appreciates your cooperation and assures you we only report ***de-identified*** (no names or medical information) data. **fye2023**