La Clínica
a californiahealth+center
SCHOOL BASED HEALTH CENTERS

Clinic 101 + ASV's !

What do you think people can go to the health center for?

All provided at no cost to you and your family ! :)

Primary Care

- Physicals, including sports physicals
- Prescriptions (medications)
- Immunizations (shots)
- Vision + hearing exams
- Sick visits
- Optical referrals
- Referrals to other health specialists
- Nutrition counseling

** You will need consent from a parent or guardian to get these services if you are under 18 **

Mental Health Care

- Individual counseling/therapy
- Counseling support + education groups
- Referrals to other needed care
- Drug and alcohol counseling

these services are confidential!

Sensitive Services

- Free Condoms
- Birth control
- STI testing + treatment
- Pregnancy tests
- Emergency contraception like plan B
- Healthy relationships
- Sexuality and gender questions
- Puberty counseling: discuss periods and other body changes

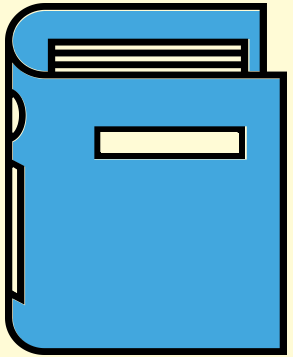
These services are all confidential (12+), which means we do not need permission from your guardian and everything we discuss stays private

Minor Consent and Confidentiality

What do we mean by "confidential?"

At what age can you start to get confidential sensitive health services (meaning without your parents or anyone else knowing) at a clinic?

Exceptions: if you say you're hurting yourself (suicidal with a plan), you will hurt someone else, or someone is hurting you we cannot keep that confidential, someone age 14+ is having sex with someone under age 14. Everything else stays within the clinic!



In CA, you have the legal right to confidential sexual health visits, health education around puberty, healthy relationships, and mental health services.

FPACT:

FPACT is a form of insurance that can be used by people in CA to cover healthcare visits related to topics that person wants to keep confidential.

ASV's
Adolescent Screening Visits

- You will know how to schedule an appointment with your school based health center
- You will become familiar with the services we offer
- You will be connected to specific resources that meet your individual needs
- You will participate in a quick visit with our health educator

How to make an appointment

Services are available at no cost to you, regardless of whether you have insurance or whether you have documentation status in the US!

All services available in many languages, including Spanish, MAM, Mandarin, Cantonese, Arabic, etc.

Come to the health center or call our phone line **(510)879-1568**! Call any time from 8:30am-4:30pm M-Th.

Appointment Request Form

We will be handing out appointment request forms! Please fill out whether you'd like an appointment or not.

Please drop it in the box up front, Thank you!

Stay Connected!

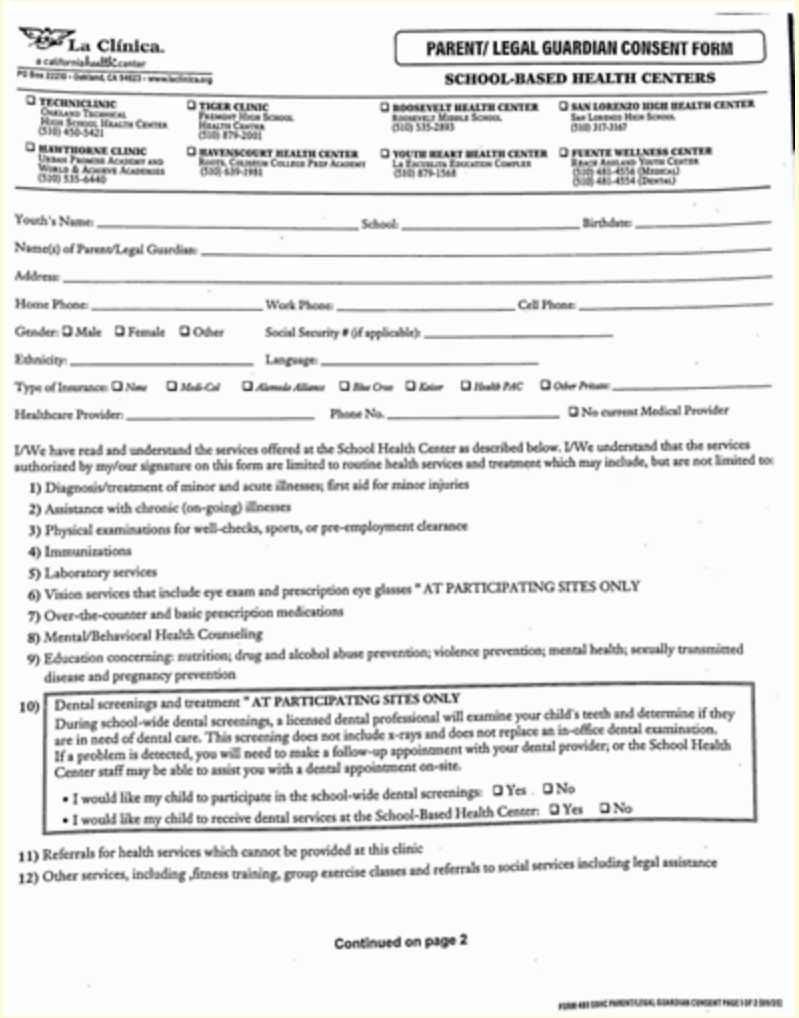
Follow our instagram! **@laclinicasbhc**

Questions????

Registration Forms

Fill out the forms handed out! We'll go over them together :)

Parent/Legal Guardian Consent Form (only for ages 11 & under)



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PARENT/ LEGAL GUARDIAN CONSENT FORM

SCHOOL-BASED HEALTH CENTERS

- ☐ **TECHNICLINIC** — Oakland Technical High School Health Center (510) 450-5421
- ☐ **TIGER CLINIC** — Fremont High School Health Center (510) 879-2001
- ☐ **ROOSEVELT HEALTH CENTER** — Roosevelt Middle School (510) 535-2893
- ☐ **SAN LORENZO HIGH HEALTH CENTER** — San Lorenzo High School (510) 317-3167
- ☐ **HAWTHORNE CLINIC** — Urban Promise Academy and World & Achieve Academies (510) 535-6440
- ☐ **HAVENSCOURT HEALTH CENTER** — Roots, Coliseum College Prep Academy (510) 639-1981
- ☐ **YOUTH HEART HEALTH CENTER** — La Escuelita Education Complex (510) 879-1568
- ☐ **FUENTE WELLNESS CENTER** — Reach Ashland Youth Center (510) 481-4556 (Medical) (510) 481-4554 (Dental)

Youth's Name: _____ School: _____ Birthdate: _____

Name(s) of Parent/Legal Guardian: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female ☐ Other Social Security # (if applicable): _____

Ethnicity: _____ Language: _____

Type of Insurance: ☐ *None* ☐ *Medi-Cal* ☐ *Alameda Alliance* ☐ *Blue Cross* ☐ *Kaiser* ☐ *Health PAC* ☐ *Other Private:* _____

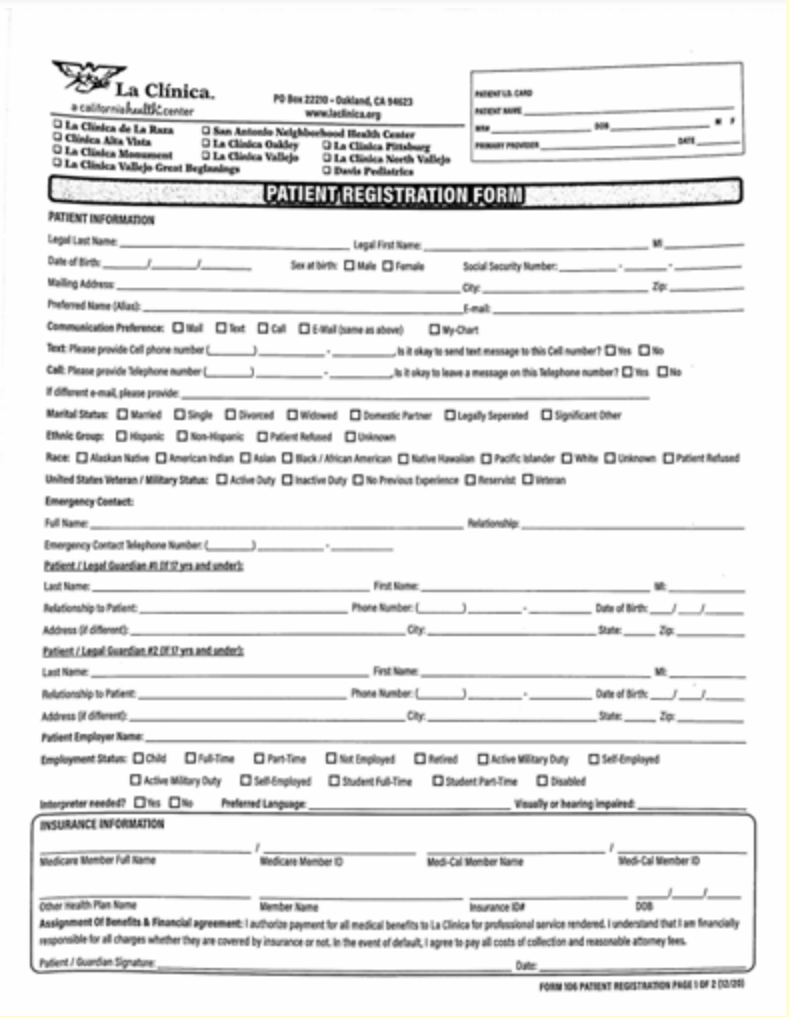
Healthcare Provider: _____ Phone No. _____ ☐ No current Medical Provider

I/We have read and understand the services offered at the School Health Center as described below. I/We understand that the services authorized by my/our signature on this form are limited to routine health services and treatment which may include, but are not limited to:

1) Diagnosis/treatment of minor and acute illnesses; first aid for minor injuries
2) Assistance with chronic (on-going) illnesses
3) Physical examinations for well-checks, sports, or pre-employment clearance
4) Immunizations
5) Laboratory services
6) Vision services that include eye exam and prescription eye glasses * AT PARTICIPATING SITES ONLY
7) Over-the-counter and basic prescription medications
8) Mental/Behavioral Health Counseling
9) Education concerning: nutrition; drug and alcohol abuse prevention; violence prevention; mental health; sexually transmitted disease and pregnancy prevention
10) Dental screenings and treatment * AT PARTICIPATING SITES ONLY
    During school-wide dental screenings, a licensed dental professional will examine your child's teeth and determine if they are in need of dental care. This screening does not include x-rays and does not replace an in-office dental examination. If a problem is detected, you will need to make a follow-up appointment with your dental provider; or the School Health Center staff may be able to assist you with a dental appointment on-site.
    - I would like my child to participate in the school-wide dental screenings: ☐ Yes ☐ No
    - I would like my child to receive dental services at the School-Based Health Center: ☐ Yes ☐ No
11) Referrals for health services which cannot be provided at this clinic
12) Other services, including ,fitness training, group exercise classes and referrals to social services including legal assistance

Continued on page 2

Patient Registration Form



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- La Clínica de La Raza
- Clínica Alta Vista
- La Clínica Monument
- La Clínica Vallejo Great Beginnings
- San Antonio Neighborhood Health Center
- La Clínica Oakley
- La Clínica Vallejo
- La Clínica Pittsburg
- La Clínica North Vallejo
- Davis Pediatrics

PATIENT I.D. CARD
PATIENT NAME
M F
DOB
PRIMARY PROVIDER
DATE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Legal Last Name: Legal First Name: MI:

Date of Birth: / / Sex at birth: ☐ Male ☐ Female Social Security Number: - -

Mailing Address: City: Zip:

Preferred Name (Alias): E-mail:

Communication Preference: ☐ Mail ☐ Text ☐ Call ☐ E-Mail (same as above) ☐ My-Chart

Text: Please provide Cell phone number ( ) - , Is it okay to send text message to this Cell number? ☐ Yes ☐ No

Call: Please provide Telephone number ( ) - , Is it okay to leave a message on this Telephone number? ☐ Yes ☐ No

If different e-mail, please provide:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Legally Seperated ☐ Significant Other

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic ☐ Patient Refused ☐ Unknown

Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black / African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unknown ☐ Patient Refused

United States Veteran / Military Status: ☐ Active Duty ☐ Inactive Duty ☐ No Previous Experience ☐ Reservist ☐ Veteran

Emergency Contact:

Full Name: Relationship:

Emergency Contact Telephone Number: ( ) -

Patient / Legal Guardian #1 (if 17 yrs and under):

Last Name: First Name: MI:

Relationship to Patient: Phone Number: ( ) - Date of Birth: / /

Address (if different): City: State: Zip:

Patient / Legal Guardian #2 (if 17 yrs and under):

Last Name: First Name: MI:

Relationship to Patient: Phone Number: ( ) - Date of Birth: / /

Address (if different): City: State: Zip:

Patient Employer Name:

Employment Status: ☐ Child ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Active Military Duty ☐ Self-Employed
☐ Active Military Duty ☐ Self-Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Disabled

Interpreter needed? ☐ Yes ☐ No Preferred Language: Visually or hearing impaired:

INSURANCE INFORMATION

Medicare Member Full Name / Medicare Member ID Medi-Cal Member Name / Medi-Cal Member ID

Other Health Plan Name Member Name Insurance ID# DOB / /

Assignment Of Benefits & Financial agreement: I authorize payment for all medical benefits to La Clinica for professional service rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney fees.

Patient / Guardian Signature: Date:

Patient Registration Form

ADDITIONAL PATIENT INFORMATION (please answer all questions)
La Clinica is a non-profit organization committed to serving the needs of our community. This information will help La Clinica access additional grants to continue helping our uninsured and underserved residents in our communities. This information also helps us identify clients who may qualify for specialty funded programs or services they were unaware they qualified for. This information will become a part of your confidential medical record.

Family Size (including patient)? _____ **What is your Annual Income (before taxes) $**_____

Has the patient been homeless in the last 12 months? ☐ Yes ☐ No
If yes, ☐ Homeless Shelter ☐ Doubling Up ☐ On Street ☐ Public Housing ☐ Other: _____

Patient's Gender Identity: ☐ Female ☐ Male ☐ Trans (MTF) ☐ Trans (FTM) ☐ Decline ☐ Non-Binary / Genderqueer ☐ Other

Patient's Sexual Orientation:
☐ Straight or Heterosexual ☐ Bi-Sexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Something Else
☐ Do Not Know ☐ Decline ☐ Non-Binary / Queer ☐ Omnisexual ☐ Asexual

Patient's Pronoun:
☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Their ☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs ☐ Xe/Xem/Xyrs ☐ Other ☐ Patient's Name ☐ Decline to answer ☐ Unknown

Consent: To provide treatment, bill your insurance, or other administrative tasks required by your insurance carrier, we must receive your consent by providing your signature below.

NOTICE OF PRIVACY PRACTICES: La Clinica is committed to protecting your health information in compliance with the law. The attached Notice of privacy practice states:

- That it is our obligation under the law to protect your information with respect to your personal health information.
- How we may use and disclose health information.
- Your rights related to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The Conditions that apply to users and disclosures not described in this Notice.
- The contact information to get further information about our privacy practices.

I, hereby, acknowledge that I have received /been offered a copy of the Consent and Notice of Privacy Practices.

Patient / Guardian Signed: _____ Date: _____

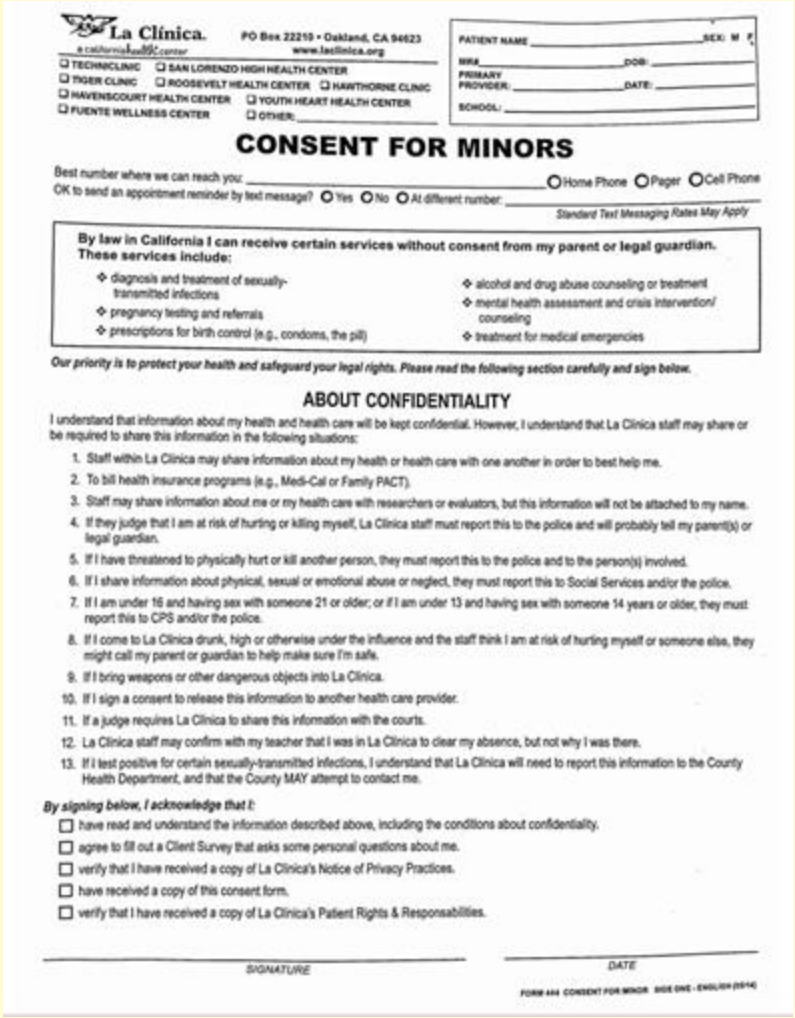
Parent / Patient's Representative Full Name: _____ Date: _____

Important Document Request:

* Please provide at least one document for each category listed below.

- ► For Children: Ages 17 and under: Birth Certificate or Guardianship Power of Attorney.
- ► Identification: Photo ID or Driver License or any unexpired identification.
- ► Proof of Residency Status: Work Permit, Residency Card (Green Card), Citizenship Certificate or American passport.
- ► Proof of Income: Last Months Pay Stub, Income Tax Declaration, W-2 Form
- ► Proof of address: Utility Bill or rent bill.
- ► Other: Social Security Card
- ► Other: Insurance Card

Consent For Minors Form



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☐ TIGER CLINIC ☐ ROOSEVELT HEALTH CENTER ☐ HAWTHORNE CLINIC
☐ HAVENSCOURT HEALTH CENTER ☐ YOUTH HEART HEALTH CENTER
☐ FUENTE WELLNESS CENTER ☐ OTHER: _____

PATIENT NAME _____ SEX: M F
MRN _____ DOB: _____
PRIMARY PROVIDER: _____ DATE: _____
SCHOOL: _____

CONSENT FOR MINORS

Best number where we can reach you: _____ ○ Home Phone ○ Pager ○ Cell Phone
OK to send an appointment reminder by text message? ○ Yes ○ No ○ At different number: _____
Standard Text Messaging Rates May Apply

By law in California I can receive certain services without consent from my parent or legal guardian. These services include:

- ❖ diagnosis and treatment of sexually-transmitted infections
- ❖ pregnancy testing and referrals
- ❖ prescriptions for birth control (e.g., condoms, the pill)
- ❖ alcohol and drug abuse counseling or treatment
- ❖ mental health assessment and crisis intervention/ counseling
- ❖ treatment for medical emergencies

Our priority is to protect your health and safeguard your legal rights. Please read the following section carefully and sign below.

ABOUT CONFIDENTIALITY

I understand that information about my health and health care will be kept confidential. However, I understand that La Clinica staff may share or be required to share this information in the following situations:

1. Staff within La Clinica may share information about my health or health care with one another in order to best help me.
2. To bill health insurance programs (e.g., Medi-Cal or Family PACT).
3. Staff may share information about me or my health care with researchers or evaluators, but this information will not be attached to my name.
4. If they judge that I am at risk of hurting or killing myself, La Clinica staff must report this to the police and will probably tell my parent(s) or legal guardian.
5. If I have threatened to physically hurt or kill another person, they must report this to the police and to the person(s) involved.
6. If I share information about physical, sexual or emotional abuse or neglect, they must report this to Social Services and/or the police.
7. If I am under 16 and having sex with someone 21 or older; or if I am under 13 and having sex with someone 14 years or older, they must report this to CPS and/or the police.
8. If I come to La Clinica drunk, high or otherwise under the influence and the staff think I am at risk of hurting myself or someone else, they might call my parent or guardian to help make sure I'm safe.
9. If I bring weapons or other dangerous objects into La Clinica.
10. If I sign a consent to release this information to another health care provider.
11. If a judge requires La Clinica to share this information with the courts.
12. La Clinica staff may confirm with my teacher that I was in La Clinica to clear my absence, but not why I was there.
13. If I test positive for certain sexually-transmitted infections, I understand that La Clinica will need to report this information to the County Health Department, and that the County MAY attempt to contact me.

By signing below, I acknowledge that I:

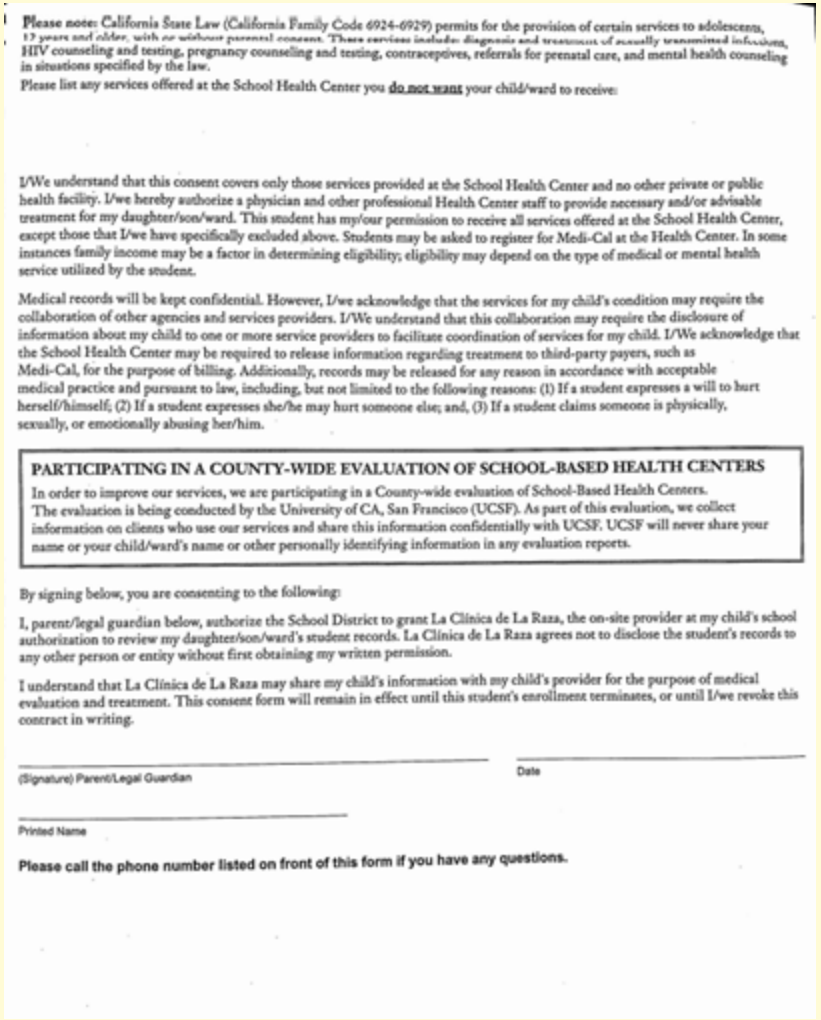
- ☐ have read and understand the information described above, including the conditions about confidentiality.
- ☐ agree to fill out a Client Survey that asks some personal questions about me.
- ☐ verify that I have received a copy of La Clinica's Notice of Privacy Practices.
- ☐ have received a copy of this consent form.
- ☐ verify that I have received a copy of La Clinica's Patient Rights & Responsibilities.

_____ SIGNATURE

_____ DATE

FORM 404 CONSENT FOR MINOR SIDE ONE - ENGLISH (05/14)

Parent/Legal Guardian Consent Form (only for ages 11 & under)



Please note: California State Law (California Family Code 6924-6929) permits for the provision of certain services to adolescents, 12 years and older, with or without parental consent. These services include: diagnosis and treatment of sexually transmitted infections, HIV counseling and testing, pregnancy counseling and testing, contraceptives, referrals for prenatal care, and mental health counseling in situations specified by the law.

Please list any services offered at the School Health Center you **do not want** your child/ward to receive:

I/We understand that this consent covers only those services provided at the School Health Center and no other private or public health facility. I/we hereby authorize a physician and other professional Health Center staff to provide necessary and/or advisable treatment for my daughter/son/ward. This student has my/our permission to receive all services offered at the School Health Center, except those that I/we have specifically excluded above. Students may be asked to register for Medi-Cal at the Health Center. In some instances family income may be a factor in determining eligibility; eligibility may depend on the type of medical or mental health service utilized by the student.

Medical records will be kept confidential. However, I/we acknowledge that the services for my child's condition may require the collaboration of other agencies and services providers. I/We understand that this collaboration may require the disclosure of information about my child to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School Health Center may be required to release information regarding treatment to third-party payers, such as Medi-Cal, for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt herself/himself; (2) If a student expresses she/he may hurt someone else; and, (3) If a student claims someone is physically, sexually, or emotionally abusing her/him.

PARTICIPATING IN A COUNTY-WIDE EVALUATION OF SCHOOL-BASED HEALTH CENTERS

In order to improve our services, we are participating in a County-wide evaluation of School-Based Health Centers. The evaluation is being conducted by the University of CA, San Francisco (UCSF). As part of this evaluation, we collect information on clients who use our services and share this information confidentially with UCSF. UCSF will never share your name or your child/ward's name or other personally identifying information in any evaluation reports.

By signing below, you are consenting to the following:

I, parent/legal guardian below, authorize the School District to grant La Clínica de La Raza, the on-site provider at my child's school authorization to review my daughter/son/ward's student records. La Clínica de La Raza agrees not to disclose the student's records to any other person or entity without first obtaining my written permission.

I understand that La Clínica de La Raza may share my child's information with my child's provider for the purpose of medical evaluation and treatment. This consent form will remain in effect until this student's enrollment terminates, or until I/we revoke this contract in writing.

(Signature) Parent/Legal Guardian

Date

Printed Name

Please call the phone number listed on front of this form if you have any questions.

FPACT Form

State of California
Health and Human Services Agency

Department of Health Care Services

HEALTH ACCESS PROGRAM
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION

Client HAP number

This Client Eligibility Certification (CEC) form is the property of the State of California, Department of Health Care Services, Office of Family Planning.
This form cannot be changed, altered, or prepopulated.

Step 1: Tell Us About Yourself

First name	Middle name	Last name	Suffix (Sr., Jr., III, IV etc.)

Address ☐ Home ☐ Mailing — Apartment number

City — State — Zip code — County of residence

Date of birth (mm/dd/yyyy)

Social Security Number (SSN)
Not having a SSN does not impact your ability to receive services.

Provider Use Only CODE

Marital status (optional)
☐ Single ☐ Never married ☐ Married ☐ Divorced
☐ Widowed ☐ Registered domestic partner ☐ I decline to answer

Race/Ethnicity (optional; check all that apply)
☐ White ☐ Asian Indian ☐ Korean
☐ Black or African American ☐ Cambodian ☐ Laotian
☐ American Indian or Alaska Native ☐ Chinese ☐ Vietnamese
☐ Native Hawaiian ☐ Filipino ☐ Guamanian or Chamorro
☐ Other ☐ Hmong ☐ Samoan
☐ Japanese ☐ I decline to answer

Are you of Hispanic, Latino, or Spanish origin? (optional)
☐ Yes ☐ No
If yes, check which ones:
☐ Mexican, Mexican American, or Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other origin

Primary language (check only one)
☐ English ☐ Armenian ☐ Cantonese ☐ Hmong ☐ Khmer/Cambodian ☐ Spanish
☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Punjabi ☐ Hindi ☐ Ukrainian
☐ I decline to answer ☐ Other

Best way to contact you if we need to talk to you
☐ Phone ☐ Text ☐ Email ☐ Mail Message Number/Email

DHCS 4461 (Revision 03/2021)

Page 1 of 7

State of California
Health and Human Services Agency

Department of Health Care Services

What is your sex? (required)
☐ Female ☐ Transgender: Male to Female
☐ Male ☐ Transgender: Female to Male

Sexual orientation and gender identity

The following information is optional and confidential. It will not be used to determine eligibility.

What is your gender? (check box that best describes your current gender identity)
☐ Female
☐ Male
☐ Transgender: male to female
☐ Transgender: female to male
☐ Non-binary (neither male or female)
☐ Another gender identity
☐ I decline to answer

Do you think of yourself as:
☐ Straight or heterosexual
☐ Gay or lesbian
☐ Bisexual
☐ Queer
☐ Another sexual orientation
☐ Unknown
☐ I decline to answer

What sex was listed on your original birth certificate?
☐ Female ☐ Male ☐ I decline to answer

Step 2: Other Health Coverage

I have had out of pocket expenses for family planning/reproductive health services covered by the Family PACT Program in the three months immediately preceding enrollment in the Family PACT Program.	☐ YES ☐ NO
I currently receive Medi-Cal benefits. If you know your Medi-Cal card number, write the number and date issued in the boxes. If you do not know, write UNKNOWN in the box. Medi-Cal Card Number ____ Issue Date ____	☐ YES ☐ NO
I have Medi-Cal with an unmet Share of Cost.	☐ YES ☐ NO
I have restricted Medi-Cal (such as "Emergency Medi-Cal") that does not cover contraceptive methods.	☐ YES ☐ NO
I have Other Health Coverage that covers contraceptive methods. Other Health Coverage may include Medi-Cal Managed Care plans, Commercial Health Plans (Kaiser, BlueCross, Health Net) or student health insurance.	☐ YES ☐ NO
I do not know if I have other health coverage (check box if you do not know).	☐
I have health insurance through Medi-Cal or Other Health Coverage on my date of service, but I cannot use my insurance because I am concerned that my spouse, partner or parent(s) may be notified or informed of my family planning visit (this is called a barrier to access).	☐ YES ☐ NO Provider Use Only CODE

FPACT Form

State of California
Health and Human Services Agency

Department of Health Care Services

Taxable Income

List yourself and your family members (spouse and children) who live with you, and the taxable income sources for each person.

If someone claims you on their taxes, list everyone claimed on that person's tax form. Sources of income includes employment, self-employment, social security (even if not taxable), tips, spousal support received, unemployment benefits, etc. Request additional pages as needed.

If you are 17 years of age or younger, your parents income is excluded. A provider can talk with you more and help you find out your family size.

Name	Relationship To You	Age	Source of Income	Taxable Monthly Income
	(Self)			

Family size:

Total taxable family income:

Step 3: Please Read And Sign Application

California Health Insurance Eligibility

I received information on how to apply and enroll for insurance affordability programs. ☐ YES ☐ NO
Please visit www.CoveredCA.com or call 1-800-300-1506 for assistance with completing the application for these programs.

I declare under penalty of perjury under the laws of the state of California that the foregoing information on this form is true and correct. I understand that giving false information may make me ineligible for this program.

Applicant Signature (or mark)	Date Signed

Privacy Statement (Civil Code § 1798 et seq.)

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

State of California
Health and Human Services Agency

Department of Health Care Services

Step 4: PROVIDER USE ONLY

Provider certification: ☐ Eligible for Family PACT Program
☐ Ineligible for Family PACT Program (Give Fair Hearing Rights)

Why client is ineligible:

Medi-Cal client eligible for Family PACT verified:
☐ Limited scope ☐ Unmet share-of-cost ☐ Barrier to Access

DECLARATION

My signature attests that based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this form is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of the CEC form which includes the Fair Hearing Rights. I also certify that the client was 1) informed of California health insurance eligibility programs through Covered California, 2) offered and received (or declined) a copy of the Notice of Privacy Practices, Nondiscrimination Policy and 3) if applicable, provided a Retroactive Eligibility Certification Form (DHCS 4001).

Print name	Signature	Date
Deactivation: If client is deactivated (no longer eligible)	Date	Reason code Provider Use Only CODE

DHCS 4461 (Revision 03/2021)