JEFFERSON COMPREHENSIVE HEALTH CENTER, INC.

405 Main Street
P. O. Box 98
Fayette, MS 39069

TELEPHONE (601) 786-3475
FAX NO: (601) 786-9980

July, 2017

Dear Parent(s) and/or Guardian(s):

Jefferson Comprehensive Health Center (JCHC) provides primary health care services through School-Based health centers located within the Jefferson County School District and the Natchez-Adams County School District. JCHC will now be offering primary health care services at:

Gilmer-McLaurin Elementary School	***170 Sgt. Prentiss Drive, Natchez, MS 39120 &***
Morgantown Middle School	***101 Cottage Home Drive, Natchez, MS 39120***

The School-Based Health Center gives your child/children an opportunity to be treated by a licensed healthcare provider for any health care needs without being absent from school. You do not have to be present for your child to be treated, however, a consent form must be signed by you in order for any services to be rendered. Furthermore, due to the fact that you do not have to be present for your child to be treated, you will not have to take time off from work.

If you do not have insurance, there will be no cost for services. However, information will be made available for students who qualify for Medicaid/CHIP. If you do have insurance, it will be billed when your child is treated. The co-pay and deductible for students will be waived.

Please find attached the consent form and a HIPAA policy notification. Please return the completed consent form and HIPAA policy notification form to your child's teacher as soon as possible in order to receive healthcare services.

If you have any questions or concerns, please contact us at the numbers listed below:

Jefferson Comprehensive Health Center, Inc. (Fayette)	***601-786-3475***
Gilmer Mc-Laurin Elementary School-Based Clinic	***601-446-5646***
Morgantown Middle School-Based Clinic	***601-445-4806***

Thanks for allowing Jefferson Comprehensive Health Center to provide health care services for your child/children.

Sincerely,

Shirley Ellis-Stampley

Shirley Ellis-Stampley
Chief Executive Officer

SES:abm
Attachments
cc: File Copy

JEFFERSON COMPREHENSIVE HEALTH CENTER
PATIENT ANNUAL REGISTRATION FORM

PATIENT INFORMATION (Photo ID is required)

NAME FIRST	MI	LAST	PATIENT ID#

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

HOME PHONE	SOCIAL SECURITY NUMBER	SEX/GENDER	DATE OF BIRTH
		○ FEMALE ○ MALE	

LANGUAGE	EDUCATION - Highest Grade Completed	MARITAL STATUS
○English ○ Spanish ○ French ○ Arabic Would you like an interpreter? ○ No ○ Yes	○ Elementary ○ High School ○ College ○ Post/Secondary /Graduate School	○ Married ○ Single ○ Divorced ○ Widowed ○ Separated ○ Partner

RACE and ETHNICITY (Check both 1 and 2):		AGRICULTURAL WORKER:
1. ○ Black/African American ○ Asian ○ American Indian/Alaska native ○ White ○ Native Hawaiian ○ Other Pacific Islander ○ More than 1 race	2. ○ Not Hispanic/Latino ○ Hispanic/Latino	○ Seasonal ○ Migrant ○ Not Applicable

HOUSING: ○ Permanent resident ○ Shelter ○ Transitional ○ Doubling up ○ Street ○ Other ○ Public Housing (HUD, Section 8)	DISABLED ○ No ○ Yes, Date_____	VETERAN ○ No ○ Yes

○ VISION IMPAIRMENT ○ HEARING IMPAIRMENT	EMERGENCY CONTACT: NAME	PHONE	RELATIONSHIP

EMPLOYMENT/STUDENT ○ Full Time Student ○ Part Time Student ○ Full Time ○ Part Time ○ Unemployed ○ Self-employed ○ Military Active Duty ○ Retired, Date_____	WORK PHONE	CELL PHONE

EMPLOYER NAME	EMPLOYER ADDRESS	CITY	STATE	ZIP

Income of patients at this Heath Center is a Federal reporting requirement. Thank you for providing this information.

TOTAL ANNUAL INCOME:	NUMBER OF PEOPLE IN YOUR HOUSEHOLD:

RESPONSIBLE PARTY INFORMATION (PARENT, GUARDIAN, Guarantor – Complete if applicable)

NAME FIRST	MI	LAST	RELATION TO PATIENT:

STREET ADDRESS	CITY	STATE	ZIP	PHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX/GENDER
		○ FEMALE ○ MALE

INSURANCE INFORMATION (Medicaid, Medicare, Private insurance card is required)

○ NO INSURANCE	○ MEDICAID, ID #	
○ PRIVATE INSURANCE Complete Information below	○ MEDICARE ID#	Do you have an insurance that covers you before Medicare? ○ No ○ Yes, please specify:

PRIMARY INSURANCE:	COPAY $	**SECONDARY INSURANCE:**	COPAY $
Following information is not required when insurance card is provided			
GROUP/POLICY#	ID#	GROUP/POLICY#	ID#

Your visit today is covered by: ○ Workman's compensation ○ Liability Insurance ○ Not applicable

How would you like to be contacted? ○ Home phone ○ Work phone ○ Mail ○ Fax ○ Electronic storage ○ Email _____
○ No preference

Primary Caregiver _____ Would you like to register for eServices? ○ Yes ○ No

Advanced Directive _____ Preferred Pharmacy _____

Provider of Choice:

Dr. Moses Young	○	NP Priscilla Jackson	○	NP Sharonda Rogers	○
Dr. Ronald Frye	○	NP Jennifer Williams	○	NP Lakeitha Turner	○
NP Crystal Cook	○	NP Jermonique King	○		
Dr. Lee G. Campbell (FAYETTE SITES ONLY)			○		

I hereby certify that the information shown above is correct.

SIGNED:	**DATE:**	**WITNESS:**	**DATE:**