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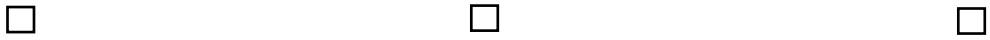

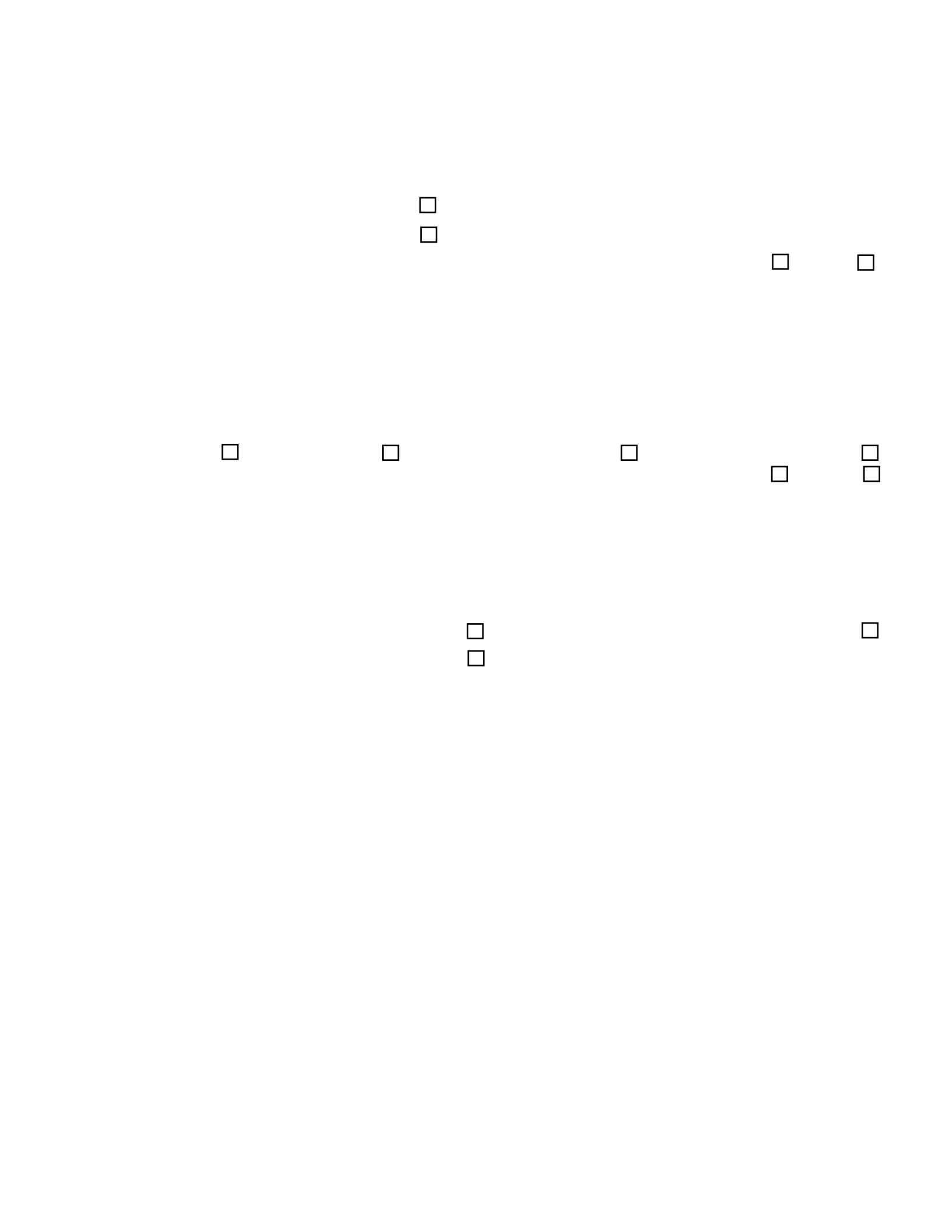

PIKE COUNTY HEALTH DEPARTMENT *BRIGHT SMILES @ SCHOOL*
Patient Registration and Consent Form

Please complete form and return if you would like for your child to have the services listed below. *Please fill out this form today and return it to your child's teacher. Please print (All questions refer to the child for whom services are requested.) With your permission, a dental hygienist will provide your child with:*

- A dental assessment of the condition of the mouth and teeth
- An age-appropriate dental cleaning
- Fluoride Varnish (to prevent future cavities)
- Dental Sealants (long-lasting plastic coatings over the back teeth)
- Oral Hygiene Instruction including nutrition counseling
- A personal Dental Report Card

(If NO services are needed, please complete CHILD'S NAME ONLY)

1. _____ _____ _____ 2. ___-___-____ 3. ___/___/___ 4. SEX (Check One) ☐ MALE ☐ FEMALE
CHILD'S NAME: Last First Middle SOCIAL SECURITY # BIRTHDATE

5. _____ _____ _____ _____ _____
MAILING ADDRESS CITY COUNTY STATE ZIP

6. _____ 7. _____ 8. ETHNICITY (Check One) ☐ HISPANIC or LATINO ☐ NOT HISPANIC OR LATINO
SCHOOL GRADE/TEACHER

9. RACE (Check One) ☐ WHITE ☐ BLACK or AFRICAN AMERICAN ☐ AMERICAN INDIAN or ALASKA NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN

10. Parent/Guardian Name: _____ Relationship to child: _____ Phone (H) _____ (C) _____ (W) _____

11. Does your child have a dentist? YES NO If so, who? _____ Date of last cleaning: _____

12. Does your child need premedication before a cleaning? YES NO 13. Does your child have any allergies to food or to medicine? YES NO If yes, please list _____

14. List any current medication your child takes (include over the counter medication or herbal medication) _____ 15. Does your child have any illnesses, diseases, or conditions including, ADHD, asthma, heart conditions, diabetes, contagious diseases? Yes No **Please explain:** _____

16. **Does your child have a Medicaid Card? (Check One)** ☐ Yes ☐No ☐Applied/ Pending ☐KCHIP **If Yes, MEDICAID Card Number** _____
If yes to Medicaid check one: ☐ Aetna Better Health (Coventry) ☐Well Care ☐Anthem ☐Humana Care Source ☐Passport

CONSENT FOR HEALTH SERVICES: (Expires 1 year from date signed)
Of my own free will I consent to care which may include screening, exams, treatment, and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) Infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue. This program does not take the place of regular check-ups at a dental office. The preventive dental services are being done by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Dentist Board member for your county is Dr. James Justice of Elkhorn Dental, who is supportive of the standards of practice of the public health hygienists and work with your Board of Health to develop and adopt protocols for these services.

This form, when signed and filled in, contains Protected Health Information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA). I understand by signing this consent, I acknowledge that I have access to a copy of the Pike County Health Department's Privacy Notice located at www.pikecountyhealth.com/v3/uploads/documents/pchd_hipaa_pp.pdf or I may request a copy by calling Pike County Health Department's main office at (606) 437-5500. I understand that my child may be screened to check the retention of these sealants by the public health dental hygienist during the following school year.

▶ _____ _____
Signature of Parent/Guardian or other Authorized Person *Date*

Please sign and date this section if you have Medicaid (PAYMENT FOR SERVICE/ASSIGNMENT OF BENEFITS) ☐ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to the local health department on my behalf, for services received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420. **I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated above.**

▶ _____ _____
Signature of Parent/Guardian or other Authorized Person *Date*

Please return to your child's homeroom teacher.
If you have any questions, please contact the Pike County Health Department at (606) 437-5500

DEN-127
REV. 3/15/18

2020-2021 Prototype Household Application for Free and Reduced Price School Meals

Apply online: INSERT URL HERE

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

Child's First Name	MI	Child's Last Name	Grade	Student? Yes	Student? No	Foster Child	Homeless, Migrant, Runaway
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

If NO > Go to STEP 3. **If YES >** Write a case number here then go to STEP 4 (Do not complete STEP 3)

Case Number:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement/ All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. Mail Completed Form To: INSERT YOUR SCHOOL/DISTRICT MAILING ADDRESS HERE

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) Apt #

City State Zip

Daytime Phone and Email (optional)

Printed name of adult signing the form

Signature of adult

Today's date

INSTRUCTIONS Sources of Income

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

fax: (202) 690-7442; or

email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Do not fill out For School Use Only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24 Monthly x 12

Total Income

How often?

Weekly	Bi-Weekly	2x Month	Monthly
○	○	○	○

Household Size

Categorical Eligibility ☐

Eligibility:

Free	Reduced	Denied
○	○	○

Determining Official's Signature	Date	Confirming Official's Signature	Date	Verifying Official's Signature	Date