EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER

2416 Swope Parkway – Kansas City, MO 64130
(816) 921-3164 Fax – (816) 861- 1270

Dear Parent(s),

Thank you for your interest in Emmanuel Family and Child Development Center. We are eager to offer your child(ren) quality childcare services.

The flowing items are required to enroll your child:

- ☐ $30 Registration Fee
- ☐ Enrollment Form
- ☐ Immunization Records
- ☐ Medical Examination Report
- ☐ Income Eligibility Form (Please complete one per family.)
- ☐ Photography and Videotaping Release
- ☐ Childcare Payment Agreement
- ☐ Authorization for Pick-up
- ☐ Parent Consent to Evaluation
- ☐ Parent and Child's Social Security Cards
- ☐ Child's Medical Insurance Cards
- ☐ Parent/ Guardian Photo ID
- ☐ Foster Child Placement Papers (if applicable)
- ☐ Current Picture of Your Child
- ☐ Proof of Birth or Proof of Pregnancy
- ☐ Proof of Income (e.g. most current tax return W-2 or paystubs, proof of SSI or TANF)
- ☐ Proof of Residency for Jackson, Clay, Platte Counties. (e.g. utility bill, rental contract, or Missouri State property tax receipt with your current address.)
- ☐ Copy of Work Schedule
- ☐ Lead Poisoning Prevention
- ☐ UMKC School of Dentistry Department of Pediatric Dentistry

After your child has been accepted for enrollment you will receive a Parent Handbook. Please refer to the Parent Handbook for the policies and procedures of the Center.

If you are receiving state assistance from the state for childcare services you will need to notify your case worker immediately with EFCDC DVN#, which is 001478584. The number to childcare authorization services is 1-855-373-4636. If you are paying or childcare services privately, please see the office about the fee schedule.

Once again, thank you for your interest in our Center. We hope to welcome you and your family to our Center soon!

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION/BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE ☐	
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE ☐	
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ No — HOW IS CHILD RELATED TO CHILD CARE PROVIDER

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ Full Time ☐ Part Time		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY?	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY?	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES
MONDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
TUESDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
WEDNESDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
THURSDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
FRIDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
SATURDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	
SUNDAY	☐	☐ AM ☐ PM	☐ AM ☐ PM	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

_____

(LIST CHILDCARE FACILITY NAME HERE)

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOME OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.	PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

PARENT'S/GUARDIAN'S SIGNATURE	DATE

CACFP REQUIREMENT

FIRST ANNUAL UPDATE		PARENT/GUARDIAN SIGNATURE	DATE
SECOND ANNUAL UPDATE		PARENT/GUARDIAN SIGNATURE	DATE
THIRD ANNUAL UPDATE		PARENT/GUARDIAN SIGNATURE	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2020 through June 30, 2021

Dear Parent or Legal Guardian:

Emmanuel Family & Child Development Center currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

Family Size	Yearly Income	Family Size	Yearly Income
1	$23,606	5	$56,758
2	$31,894	6	$65,046
3	$40,182	7	$73,334
4	$48,470	8	$81,622

For each additional family member, add $8,288

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however, you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Center Owner/Director

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER ( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐ MONTH ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ SNAP (Food Stamp) ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

MO 580-1314 (2-11) CACFP-205

This institution is an equal opportunity provider.

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER
2416 Swope Parkway - Kansas City, MO 64130
816-921-3164 FAX 816-861-1270

Photography & Videotaping Release

From time to time Emmanuel Family & Child Development Center or its subsidiaries, or the news media may videotape or photograph your child and/or their class.

By signing my name on this document, I acknowledge and agree:

- That Emmanuel Family & Child Development Center or its subsidiaries have my permission to allow the recording of my child's likeness or photograph for future use.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to my child's participation in activities which may result in such photography or videotaping.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to the use of such photography or videotaping.
- That I and/or my child will receive no financial or in-kind compensation for the use of my child's likeness or image by Emmanuel Family & Child Development Center or its subsidiaries as well as the media.
- This authorization in no way guarantees that my child's likeness or image will be used.

If I do not wish for my child's likeness or image to be used according to such above-stated conditions, I acknowledge and agree that I will provide the Director with written notification of such intent, prior to my child's enrollment within Emmanuel Family & Child Development Center, or at a later date if need should arise.

I hereby authorize my child to participate in activities which may be videotaped or photographed, and acknowledge my understanding and agreement to the terms and conditions stated with this document.

_____

Child's Name

_____

Parent or Guardian Signature & Date

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER
2416 Swope Parkway - Kansas City, MO 64130
816-921-3164 FAX 816-861-1270

Childcare Agreement For:

_____
Child's Name and Date of Birth

_____
Child's Name and Date of Birth

_____
Child's Name and Date of Birth

I understand the hours of the program for which I have registered my child and agree to adhere to them promptly. I also understand that I must escort my child into the building and leave him/her in the care of a staff member. The staff will release the child only to the parents or to the persons designated that is 18 years or old.

I further agree to read the Center's guidelines when received and to adhere to those guidelines as stated. I acknowledge that I understand and have received a copy of the Center's current prices and payment policies, including but not limited to the following policies:

A. All registration fees, activity fees, co-pays, and tuition are non-refundable in whole or in part. I have been informed that the payment is due promptly on Mondays and is late after Friday, at which time late fees may be assed. EFCDC has the right to terminate the contract due to repeated late payments, returned checks, or in the event that the child(ren)'s behavior endangers the other children or the Provider.
B. If I receive state childcare assistant, I know I am responsible for making sure that my case remains open during the duration of my child's attendance at the Center or I will be charged full tuition for my children. If my childcare case does close and my children have attended the center after it closes I am responsible for paying full tuition for my children.
C. Because my child's spot is reserved, I am responsible for payment of tuition/copay even if my child is absent due to sickness, vacation, or any other reason. I understand that a collection agency will be used to collect any monies not paid on this account in the event that I withdrawal my child(ren) from the Center leaving a remaining balance.
D. I may take up to 2 weeks (as a block of 5 consecutive days each) vacation credit (non-cumulative from year to year) without obligation for tuition if my child has been enrolled for 12 consecutive months on a continuing basis, and provided that I give the Center two weeks' notice of vacation.
E. Late fees are charged for late payments and pickups.

The Director and staff are available for individual conferenced concerning your child's adjustment to and progress in the school program. If any special problems arise in the school affecting your child, such occurrences will be promptly brought to your attention. In the event of withdrawal from the program, 2 weeks withdrawal notice is required; your regular tuition/co-pay charges continue during this 2 week notice period. A new registration fee will be due upon re-enrollment.

The agreed upon fee for childcare is $ _____ per week, Overtime services may be provided at the discretion of EFCDC and at the rate of $ _____ per hour.

_____ _____ _____
Parent or Guardian Signature Date Parent Social Security Number

_____ _____
EFCDC Representative Date

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816-921-3164 FAX 816-861-1270

Authorization for Pick-Up

Child's Name _____

Parent's Name _____

Home #: _____

Work #: _____

Cell #: _____

Person(s) listed below are authorized by the parent/guardian to take their child(ren) from the facility.

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

EFCDC Office Staff will check each person for identification. We will not all any child to be removed from the Center without proper authorization.

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FAMILY & CHILD DEVELOPMENT CENTER

2416 Swope Parkway - Kansas City, MO 64130
816-921-3164 FAX 816-861-1270

Parent Consent to Evaluation:

The first five years are very important for your child because this time sets the stage for success in school and later in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please sign below indicating that you agree to have your child participate in the screening/ monitoring programs used at Emmanuel Family & Child Development Center.

- The Ages & Stages Questionnaires (ASQ-3)
- The Department of Education and Second Education Core Competencies (DESE)
- The Devereux Early Childhood Assessment Development Screenings (DECA)
- Rockhurst University Speech and Language Therapy

_____

Parent or Guardian Signature & Date

_____

Child's Name

_____

Child's Date of Birth

_____

Child's Primary Care Physician

Health Department
City of Kansas City, Missouri

Childhood Lead Poisoning Prevention

(816) 513-6048

2400 Troost Avenue, Suite 3400
Kansas City Missouri 64108

What does lead do to Children?

Lead affects all body systems, but especially the brain and nervous system causing problems such as hyperactivity, learning difficulties, impaired growth, lower IQ.

Where is lead? Everywhere-but particularly:

Lead-based paint, contaminated soil, dust, air, water, hobby supplies, folk medicine, and poorly glazed pottery.

Precautions you can take:

Good nutrition, frequent hand washing and housecleaning to remove lead-contaminated dust, safe clean-up and disposal of paint chips, avoidance of folk remedies and poorly glazed pottery.

CONSENT FORM

I give permission for my child to have a lead screening blood test. I understand this procedure involves a finger stick to obtain a few drops of blood. The test will be performed by nurses from the Kansas City, Missouri Health Department and results may be released to your child's day care program.

(Please Print)

Child's Name:_____ Today's Date:_____

Sex:_____ Race:_____ Date of Birth:_____ Medicaid #:_____

Address:_____
Street City State Zip code

Phone#:_____ Signature – Parent/Guardian:_____

Alt. Phone#:_____ Print Parent/Guardian Name:_____

For office use only: Date of Screening:_____

Screening Site:_____ RN:_____

swopeHEALTH

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Birth Date:	Sex:
«LastName»	«FirstName»	«MiddleInitial»	«DOB»	☐M ☐F

Street Address:	City	State,	Zip:	County:
«MailingAddress1»	«MailingAddress2»			

Mailing Address: ☐Same as above	Social Security Number:

Home Phone Number:	Cell Phone Number:	Work Phone Number:
«HomePhone»	«CellPhone»	«WorkPhone»

Email Address:	Marital Status:	Homeless Status:
«Email»	☐Divorced ☐Married ☐Single ☐ Separated ☐Widowed	☐Transitional ☐Doubling Up ☐Homeless Shelter ☐Other ☐Homeless ☐Seasonal ☐Migrant

Race: ☐Asian ☐American Indian/Alaskan Native ☐Black or African American ☐White ☐Native Hawaiian ☐Pacific Islander ☐Unreported/Refused to Report	Primary Language: _____ Translator Needed: ☐Yes ☐No
Ethnicity *(choose only one)*: ☐Hispanic/Latino ☐Not Hispanic ☐Refused to report	Veteran Status *(choose only one)*: ☐Yes ☐No

Employer Name :	Employer Status:	Student:
«EmployerName»	☐Full Time ☐Part Time	☐es ☐No

Primary Care Provider (PCP) Name: «PcpFName» «PcpLName» «PcpInitials»

Does the patient have any problems with: ☐Vision ☐Hearing ☐Reading ☐Speaking
Explain:

Parent/Guardian OR Responsible Party Name:	Address: ☐Same as above	Phone Number:
«GrFName»«GrLName»	«GrAddr1» «GrAddr2»	

Parent/Guardian OR Responsible Party SSN:	Birth Date:	Relationship:
«GuarantorSSN»	«GuarantorDOB»	«RelToPatient»

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the Patient Service Representative)

Person responsible for bill:	Birth date:	Address (if different):	Primary Phone Number: ( )

Occupation:	Employer:	Employer Phone Number:

Patients relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Step Child ☐Other

Primary Medical Insurance:	☐Medicare ☐Medicaid ☐Blue Cross Blue Shield ☐Other:		
Subscriber's Name:	Birth Date:	Policy #:	Group #:
Name of Secondary Medical Insurance (if applicable):	Subscriber's Name:	Birth Date:	Policy #: Group #:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Primary Phone Number
«EmergencyName»		«EmergencyPhone»

Signature: _____ Date: _____

swopeHEALTH

Sliding Fee Discount Eligibility

It may be necessary to ask some personal questions in order to determine eligibility for a discount on medical, dental or qualified behavioral health services. This information is private and confidential and is kept on file at Swope Health. Income verification is determined once a year and requires proof of income and proof of address documents to be returned to Swope Health Services. (Family size and annual gross household income are used to calculate discount and level of payment.)

List all Household Members that live in the home.

	Name	Date of Birth	Relationship
1			
2			
3			
4			
5			
6			
7			
8			

Do you have any wage income from any of the listed household members:

Household Member Name	Hourly Rate	Hours Worked	Bi-weekly Income	Hours Worked

Do you have income from the any of the following sources and if so, how much per month?

Sources	You	Your Spouse	Your Children	Other Persons	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support-Alimony					
Other (Specify)					

The Sliding Fee, Health Levy, and all other discount programs have been explained to me, and I acknowledge that deliberately providing false or incomplete information in regard to determining the level of sliding fee scale discount can disqualify me or family members from being eligible for this program. I also understand that if I do not provide proof of income and/or proof of address within 30 days, I may be billed at full price for service rendered. Information can be returned in person or to PSRGroupMail@swopehealth.org

Signature_____ **Date**_____

April 2020

swopeHEALTH

SELF-DECLARATION OF INCOME

I certify that my current annual household income is $_____ and my family size is _____. I declare that all of my dependents are 18 years old and younger or disabled. I understand that this self-declaration is good for 30 days only. To receive a discount on services for a 12 month period, I will need to provide proof of my income by_____.

☐ decline to participate in the sliding fee discount program.

_____ _____
Patient/Parent/Legal Guardian Signature Date

FINANCIAL RESPONSIBILITY

I hereby certify that I have not knowingly withheld any information or income or other financial resources. The amounts I have disclosed are true and correct to my knowledge. I understand that hiding information or providing false information may result in prosecution or being removed from Medicaid, Medicare and any other Government funded programs.

I understand the charges I have to pay for are after I received credit for all appropriate discounts and all collections received by Swope Health from health insurance benefits for the above named individuals. I am responsible for the remaining balance.

I agree to pay these charges on the day that the services are provided, within 10 days of receipt of the statement from Swope Health Services or by some other payment arrangement agreed to by the Swope Health Patient Relations Office, telephone 816-599-5700. I also authorize release of information about any claim to my health insurance carriers, or my state medical assistance agency and/or to the Department of Mental Health.

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Witness Date

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

I, having registered at Swope Health Services for the purposes of obtaining health services, do hereby, voluntarily consent to diagnostic and treatment services for _____ (Patient Name), as might be provided by or at the direction of a physician, dentist, other health care professional or other qualified member of the staff of the Swope Health Services to me according to his/her judgment. By signing below, I also consent to treatment by students in residency and/or affiliation programs with Swope Health Services.

- I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Center.
- I recognize that I may be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia.
- I am aware that health services are person specific, and I acknowledge that no guarantees have been made to me as to the results of any treatment services,
- I hereby authorize Swope Health Services to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience any specimen or tissue taken from my body during my treatment.

This form has been fully explained to me, and I certify that I understand its contents.

_____ _____
Patient/Parent/Legal Guardian Signature Date

swopeHEALTH

Acceptable Documentation for Sliding Fee Program

If you are not insured, fees for clinic services are based on your income and family size and may be reduced if you live on a limited income, according to state and federal guidelines. To qualify for discounts, you must present the following information, as applicable, when you register:

Proof of Income: (please provide applicable documentation for each household member):

- Current Paycheck Stub
- Letter on Company Letterhead including your hourly rate, gross pay, and the pay period
  *If your employer does not have company letterhead, we will accept a notarized letter.
- W2 Forms (Adjusted Gross Income)
- Current Financial Aid
- Current Unemployment Determination Letter
- Social Security, Pension, Trust, Disability Award Letter , Food Stamp Summary, or Child Support Check
- Bank Statements showing consistent Payroll deposits
- Current Tax Information

Proof of Address: (please provide if you live in the city of Kansas City, Missouri)

- Driver's License (address must match current address listed on registration)
- A current piece of mail addressed to you (within 30 days)
- Lease or Mortgage Agreement
- Mail received from the Government (Social Security, pension, trust, SSI Disability Award letter, food stamp budget summary or child support check)
- Current Utility Bill (electric, gas or telephone)
- Current Paycheck Stub with your current mailing address located on the check stub
- Current Bank Statement
- Attestation from a Social Worker (For Homeless Individuals)

Additional Information

- For elderly parents living with adult children or adult grandchildren, include income if adult children or adult grandchildren claim parents as dependents on their tax return. Otherwise, parents should be considered as independent for the purposes of income, without their adult children's income.
- Non-cash items such as food stamps are not included in income.

Please Note: This information must be given to Swope Health within 30 days or you may be billed at full price for services rendered. Information can be returned in person or to PSRGroupMail@swopehealth.org

April 2020

swope HEALTH

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I was offered a copy of the Swope Health Notice of Privacy Practices. I have been given the opportunity to read, or have read to me, the Notice of Privacy Practices, which describes how medical information about me may be used and disclosed. I agree with the Notice of Privacy Practices and understand that at any time upon request, I may obtain a copy of it.

Patient/Parent/Legal Guardian Signature _____ Date _____

RECEIPT OF PATIENT RIGHTS & RESPONSIBILITIES

I was offered a copy of Swope Health "Patient Bill of Rights," also known as Patient Rights and Responsibilities. This document lists my rights as a patient, including the right to access my own information and the right to formulate an advanced directive, among other things. I have been given the opportunity to read it, or have it read to me. I understand what it means, what I might expect from this health care facility and what is expected of me and my family member(s) as registered patients here.

Patient/Parent/Legal Guardian Signature _____ Date _____

OPTIONAL: PERSONAL REPRESENTATIVE DESIGNATION

A Personal Representative is a person authorized by the patient to obtain information and act on the behalf of another person in making health care related decisions. I understand that completing this form will allow Swope Health to speak to my Personal Representative regarding all health information, including but not limited to illnesses, injuries, test results, medications, and sensitive data that may include:

- Alcohol or substance abuse problems;
- Genetic diseases or tests;
- Family Planning information;
- HIV/AIDS;
- Sexually Transmitted Diseases; and/or
- Mental Health and Developmental Disabilities.

I also understand it will give the Personal Representative the ability to do the following on my behalf:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments; and/or
- Access protected health information.

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization;
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing;
- Swope Health Services may not condition my treatment on this; and
- Swope Health Services is not responsible or liable for disclosure of the above information to the extent indicated and authorized herein.

I hereby designate the below person as my Personal Representative:

Name of Personal Representative: _____

Personal Rep Date of Birth: _____ Phone Number: _____

This authorization will expire **(check one)**: ☐ Until revoked in writing ☐ Date: _____

Patient/Parent/Legal Guardian Signature _____ Date _____

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COMMUNICATION PREFERENCES

Swope Health is committed to protecting your information. SHS would like to send you information about your healthcare using the methods you prefer.

Please initial next to the forms of communication you authorize Swope Health Services to use to communicate with you.

_____ **Patient Portal**

_____ **Voicemail**

_____ **E-Mail**

_____ **Text Message**

I hereby authorize Swope Health Services to communicate my health information to me using the methods I have consented to above. I understand that the Patient Portal is a secure method of communication, but that communication such as text messaging, email, and voicemail may be considered unsecure and could be seen or heard by others.

_____ _____

Patient/Parent/Legal Guardian Signature Date

HEALTH INFORMATION EXCHANGE

Swope Health participates in three Health Information Exchange networks: Missouri Health Connection ("MHC"), Lewis and Clark Information Exchange ("LACIE"), and Kansas Health Information Network ("KHIN"). These secure networks allow doctors and other caregivers to electronically share a patient's health records with other participating organizations, to improve coordinated care.

I understand a full list of member organizations can be viewed at the MHC, LACIE, and KHIN websites. I also understand only authorized health care organizations and professionals involved in a patient's treatment, care, quality improvement, or payment are allowed access to a patient's records and privacy laws still apply.

☐ I agree to participate in the Health Information Exchange and allow other healthcare providers to be able to see my health records from both before and after today's date. I understand this may include illnesses or injuries, test results, medicines I am taking or have taken, and sensitive data including but not limited to: alcohol or substance abuse problems, sexually transmitted diseases, HIV/AIDS, family planning information including abortions, and mental health disabilities.

☐ I decline to participate in the Health Information Exchange. I understand other organizations who are trying to help me by providing medical care may not have access to my medical history.

_____ _____

Patient/Parent/Legal Guardian Signature Date

swope HEALTH

INFORMED CONSENT FOR TELEHEALTH

Patient Name: _____ Date of Birth: _____

To better serve the needs of our community, Swope Health may provide health care services through interactive video communications and the electronic transmission of information. This process is referred to as "telehealth" or "telemedicine." This may assist in the evaluation, diagnosis, management, and treatment of some health care problems.

Before participating in telehealth services, please understand the following:

1. I understand I may be evaluated and treated by a health care provider or specialist who is at a different location than me. I understand this means the health care provider must rely on the information reported to make recommendations since we are not in the same room.
2. I understand that while Swope Health takes steps to ensure the communication is secure, there is a risk that security protocols could fail.
3. I will be informed if any additional Swope Health staff are to be present for the telehealth session. I understand all laws in place to protect my privacy and confidentiality still apply to telehealth services.
4. I understand there are additional potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
5. I understand that my health care provider or I can discontinue the telehealth session at any time.
6. I have had the alternatives to telehealth explained to me, and I understand that I can be seen in person at another time. I understand my participation in telehealth is completely voluntary.
7. I understand that while this telehealth session will not be recorded, it will be documented in my medical record. I further agree not to record any portion of the telehealth session.

_____ _____

Patient or Representative Signature Date

swopeHEALTH

SWOPE HEALTH SERVICES
DENTAL OUTREACH

CHILD	
Name _____ Last First MI Address _____ City, State, Zip _____ Phone _____ Date of Birth _____ Gender: Male ☐ Female ☐ Other ☐ Language: ☐ English ☐ Other - _____	

HEALTH HISTORY

Circle any of the following that your child had or presently has: Heart/Vascular Disease, Heart Murmur, Rheumatic Fever, Asthma, Diabetes, Liver Disease, Kidney Disease, Epilepsy/Seizures, Bleeding Tendency, Cancer/Leukemia, Anemia, ADHD

Does your child have any dental pain? Yes ☐ No ☐ **If yes, how long?** Day(s) [ ] Week(s) [ ] Month(s) [ ]

(Recommended for children age 3 years and older)

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Please list any other health problems or conditions your child has. Some conditions may affect treatment. _____

Circle any of the following that your child is allergic to or had an adverse reaction to:

Aspirin Local Anesthetic Penicillin
Penicillin Latex (balloons, gloves, rubber, etc.) Erythromycin Other: _____

Is your child taking medications? Yes ☐ No ☐

List Medications

_____
_____
_____

Physician Name

_____

Physician Phone # _____

I give my informed consent for the dentists and their staff to take x-rays of my child's mouth and provide the care the dentist deems necessary for the treatment of his/her oral condition. I will receive information advising me of my child's oral health needs. I authorize the release of information for any applicable insurance coverage.

I also authorize Swope Health Services to share my child's dental examination information with Emmanuel family and child development center_School staff.

Your child's visit may include the following: Dental Exam Dental x-rays Cleaning Fluoride Application Sealants

To continue dental care at a Swope Health Services Dental Clinic, please call for an appointment at 816-599-5731.

_____ _____
Signature Parent/Guardian Date

_____ _____
Dentist Signature Date