Downe Township Elementary School
Kids' Center

A CompleteCare Health Network
School-Based Youth Services Program

Powered by CompleteCare

220 MAIN STREET • NEWPORT, NJ 08345 • PHONE: 856-447-4673 x5

Counseling • Recreation/Enrichment • Academic Support • Community Resources • Prevention

CONSENT FORM

The goal of Kids' Center, a School-Based Youth Service Program funded by generous grants from the new Jersey Department of Children & Families (DCF) and under the direction of CompleteCare Health Network (CCHN), is to help youth people navigate their adolescent years, finish their education, obtain skills leading to employment or continuing education, and graduate happy, healthy, and drug/alcohol free. With this purpose in mind, Kids' Center provides a comprehensive set of services to students and families with the Downe Township Elementary School community. Any student attending this school is eligible to receive services with parental consent.

Services include:

- Individual, Group, and Family Support Counseling
- After-School Recreation & Enrichment Opportunities
- Alcohol, Drug, and Violence Prevention Programs & Health Education
- Healthy Youth Development & Life Skills
- Academic Support, Tutoring, Mentorship, and Post-Graduation Planning, Linkage to Community Resources

I, _____ consent to have _____
Parent/Guardian (PRINT) Student Name (PRINT)

receive services provided by the School-Based Youth Service Program (SBYSP) of Downe Township Elementary School, except: _____

_____

_____

I consent to the Kids' Center School-Based Program obtaining appropriate school records and collaborating with DTE staff. I understand important information about by child will not be released without prior consent. I also consent to allow my child to be photographed in group settings for media publications about the school program and to participate in School-Based Program surveys to determine the effectiveness of our services.

_____ (Initial Here) I understand that CompleteCare Health Network abides by all state/federal HIPPA laws and that a copy of the "Notice of Privacy Practices" & "Patient's Rights" can be found online at www.downeschool.org, at our office within the school, or at any CompleteCare Health Network site within the southern New Jersey area. Please know that no personal information will be released unless appropriate permission is given by the student and/or guardian.

☐ I consent to allow CCHN to treat me via a telemedicine visit as needed or requested.
☐ I understand that copy of my rights as a patient is hanging in the health center and a copy is available upon request.
☐ I understand the notice of privacy practices is posted in the health center and I understand that a copy is available upon request.
☐ Please check here if you want a hard copy of the "Notice of Privacy Practices" & "Patient's Rights" sent to your home address.

PARENT/GUARDIAN SIGNATURE DATE STUDENT SIGNATURE DATE

REGISTRATION FORM

220 MAIN STREET • NEWPORT, NJ 08345 • PHONE: 856-447-4673 x5

Counseling • Recreation/Enrichment • Academic Support • Community Resources • Prevention

1. **Student Name:** _____ 2. **Student ID Number:** _____

3. **Address:** _____

_____

_____

4. **Phone Number:** _____ 5. **Date of Birth:** _____

6. **Gender:** _____ 7. **Grade:** _____

8. **Ethnicity:** Black White Hispanic/Latino Asian Multi-Racial Other _____

9. **Who can we thank for referring you to Kids' Center?**
Self Friend Parent Nurse Guidance/CST Teacher Principal Other _____

10. **What type of medical insurance to you have? (SBYSP does not bill insurance for any service.)**
Medicaid NJ Family Care Private Do Not Know Other _____

11. **Parent/Guardian contact information:**

Name: _____

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

Relationship to student: _____

Name: _____

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

Relationship to student: _____

Please answer the following questions:
The following questions will assist us in linking your family with appropriate community resources.

Is your child currently a patient at CompleteCare Health Network: ☐ Yes ☐ No

Are you currently receiving state services, like NJ Family Care, TANF, or WIC? ☐ Yes ☐ No

Do you have a primary care provider? ☐ Yes ☐ No

Would you like information on? ☐ Medical Insurance ☐ Dental Insurance ☐ Eye Care ☐ Behavioral Health

Should you have questions or concerns, do not hesitate to contact our office at 856-447-4673 x5. Thank you!

COMMUNITY HEALTH CARE, INC.
PATIENT RIGHTS

Each patient receiving services in this ambulatory care facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms of any rules and regulations it has adopted governing patient conduct in the facility;

2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;

3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have the right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;

4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;

5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;

6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including investigation of new drugs and medical devices;

7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;

8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

9. To confidential treatment of information about patient information in the patient's medial record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires information, or unless the release of information is required by and permitted by law, a third-party payment contact, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patients identity is masked;

10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including but not limited to auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;

11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntary by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;

12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious benefits or practices, or any attendance at religious services, shall be imposed upon thew patient;

13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility;

14. To give informed, written consent prior to the start of specified non-emergency procedures or treatments only after a physician has explained specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation and any reasonable medical alternatives for care and treatment;

15. To receive a copy of the CHCI payment rates and an itemized bill and an explanation of the charges upon request. The patient has the right to appeal the charges.

16. To have prompt access to the information contained in the patient's medical record, unless a physician prohibits such access as detrimental to the patient's health.

17. To be assisted in obtaining public assistance and the private health care benefits to which the patient may be entitled. This includes being advised that they are indigent or lack the ability to pay and that they may be eligible for coverage, and receiving the information and other assistance needed to qualify and file for benefits or reimbursement,

18. To be given a summary of the CHCI patients rights, as approved by the New Jersey State Department of Health, and any additional policies and procedures established by the hospital involving patient rights and responsibilities. A summary of these patient rights, as approved by the New Jersey Department of Health, shall be posted conspicuously in public areas at Community Health Care, Inc.

19. Patient(s) or family member(s) who have a question or want to file a complaint about possible patient rights violations, please call the Administrative Staff at Community Health Care, Inc. Bridgeton: 451-4700;

20. Patients have the right to appropriate assessment and management of pain.

21. Patients have the right to be involved in all aspects of care, and the patient care process respects patient's psychosocial, spiritual and cultural values.

22. Patients have the right to receive assistance in formulating advance directives.

Signature_____(Patient/Guardian) Date_____ c: Patient Rights: 11/00

COMMUNITY HEALTH CARE, INC.
PATIENT RESPONSIBILITIES

Each Patient receiving services in this ambulatory care facility shall have the following responsibilities:

1) It is very important that you keep all of your appointments and you must show up on time or you may not be seen. If you cannot keep your scheduled appointment, you must call and notify us before 24 hours prior to your appointment. Failure to do so will result in a "no show" and three (3) no-shows within a 3-month period can result in dismissal from the practice.

2) Please bring all of your insurance cards at every visit or you will be required to pay at the time of the visit. Also, bring with you to every visit – all of your medications. Bring your children's Shot Records to each visit.

3) If you have an emergency on the weekend or after the office is closed, you may call (856) 451-4700 in Bridgeton or (856) 691-3300 in Vineland.

4) Please call for prescription refills or routine problems when the office is open. Please note that referrals and prescription refills will be done within 48 hours or two working days following receipt of your call/request.

5) Our doctors work only at Bridgeton and Newcomb hospitals. We request that you only use Bridgeton and Newcomb Emergency Rooms, unless it is a life threatening emergency and the ambulance has to take you to another hospital. Please call the doctor before you go to the emergency room.

6) You will be given a card with your own Doctor's, Nurse Practitioner's or Dentist's name on it. Please always ask for your appointments with that Doctor, Nurse Practitioner or Dentist so you can see them each visit.

7) It is your responsibility to provide accurate and complete information about complaints, past illnesses, hospitalizations, medications, advance directives, allergies and other matters of care.

8) It is your responsibility to follow the plan of care recommended and/or follow-up instructions recommended by your Health Care Provider, and understand the consequences of non-compliance.

9) It is your responsibility to tell us when you do not understand a treatment course or care decision.

_____ _____
Patient/Guardian Signature Date

Chart #_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who We Are

This Notice describes the privacy practices of Community Health Care, Inc., its employed physicians, nurses, and other personnel. It applies to services furnished to you at all inpatient and outpatient facilities at which Community Health Care, Inc. provides services to patients.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI (including, if any, your HIV/AIDS, Sexually Transmitted Disease (STD) or Tuberculosis information), in order to treat you, obtain payment for services provided to you and conduct our "health care operations" as detailed below:

- Treatment. We use and disclose your PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

- Payment. We may use and disclose your PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care.

- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our Patient Relations Department in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

We may also disclose PHI to another health care facility to which you have been transferred when such PHI is required for it to treat you, receive payment for services it renders to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Use or Disclosure for Directory of Individuals in Community Health Care, Inc. We may include your name, location in Community Health Care, Inc., general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, religious affiliation will only be disclosed to members of the clergy.

C. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we

would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

D. Fundraising Communications. We may contact you to request a tax-deductible contribution to support important activities of Community Health Care, Inc.. In connection with any fundraising, we may disclose to our fundraising staff demographic information about you (e.g., your name, address and phone number) and dates on which we provided health care to you, without your written authorization. If you do not want to receive any fundraising requests in the future, you may contact our Privacy Office at (*to be identified at a later date*).

E. Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

F. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

G. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

H. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process, such as, under New Jersey law, the request of a person (or his/her insurance carrier) against whom you have commenced a lawsuit for compensation or damages for your personal injuries.

I. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

J. Decedents. We may disclose your PHI to a medical examiner as authorized by law.

K. Organ and Tissue Procurement. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

L. Research. We may use or disclose your PHI without your consent or authorization if our Institutional Review Board approves a waiver of authorization for disclosure.

M. Health or Safety. We may use or disclose your PHI to prevent or lessen a threat of imminent, serious physical violence against you or another readily identifiable individual.

N. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

O. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

P. As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, we only may use or disclose your PHI when you grant us your written authorization on our authorization form ("Your Authorization"). For instance, you will need to sign an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

B. Marketing. We must also obtain your written authorization ("Your Marketing Authorization") prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter

without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

C. HIV/AIDS Related Information. Your Authorization must expressly refer to any HIV/AIDS related information about you in order to permit us to disclose any HIV/AIDS related information about you. However, there are certain purposes for which we may disclose your HIV/AIDS information, without obtaining Your Authorization: (1) your diagnosis and treatment; (2) scientific research; (3) management audits, financial audits or program evaluation; (4) medical education; (5) disease prevention and control when permitted by the New Jersey Department of Health and Senior Services; (6) to comply with a certain type of court order; and (7) when required by law, to the Department of Health and Senior Services or another entity. You also should note that we may disclose your HIV/AIDS related information to third party payors (such as your insurance company or HMO) in order to receive payment for the services we provide to you.

D. Genetic Information. Except in certain cases (such as a paternity test for a court proceeding, anonymous research, newborn screening requirements, or pursuant to a court order), we will obtain your special written consent prior to obtaining or retaining your genetic information (for example, your DNA sample), or using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information for any other reason only when Your Authorization expressly refers to your genetic information or when disclosure is permitted under New Jersey State law (including, for example, when disclosure is necessary for the purposes of a criminal investigation, to determine paternity, newborn screening, identifying your body or as otherwise authorized by a court order.)

E. Sexually Transmitted Disease Information. Your Authorization must expressly refer to any sexually transmitted disease information about you in order to permit us to disclose any information identifying you as having or being suspected of having a sexually transmitted disease. However, there are certain purposes for which we may disclose your sexually transmitted disease information, without obtaining Your Authorization, including to a prosecuting officer or the court if you are being prosecuted under New Jersey law, to the Department of Health and Senior Services, or to your physician or a health authority, such as the local board of health. Your physician or a health authority may further disclose your sexually transmitted disease information if he/she/it deems it necessary in order to protect the health or welfare of you, your family or the public. Under New Jersey law, we may also grant access to your sexually transmitted disease information upon the request of a person (or his/her insurance carrier) against whom you have commenced a lawsuit for compensation or damages for your personal injuries.

F. Tuberculosis Information. Your Authorization must expressly refer to your tuberculosis information in order to permit us to disclose any information identifying you as having tuberculosis or refusing/failing to submit to a tuberculosis test if you are suspected of having tuberculosis or are in close contact to a person with tuberculosis. However, there are certain purposes for which we may disclose your tuberculosis information, without obtaining Your Authorization, including for research purposes under certain conditions, pursuant to a valid court order, or when the Commissioner of the Department of Health and Senior Services (or his/her designee) determines that such disclosure is necessary to enforce public health laws or to protect the life or health of a named person.

G. Psychotherapy Notes. We must obtain your written authorization to use psychotherapy notes kept as a result of treatment of you except under certain circumstances.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with the Director or us.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke Your Authorization or Your Marketing Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below. [A form of Written Revocation is available upon request from the Privacy Office.]

E. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your medical records, please obtain a record request form from the Medical Records Office and submit the completed form. If you request copies, we will charge you up to $1.00 per page -- for the first 100 pages, and $0.25 per page after that -- up to a maximum of $200.00 per record. We will also charge you for our postage costs, if you request that we mail the copies to you.

You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to pregnancy, abortion, sexually transmitted diseases, substance use or abuse, or contraception and/or family planning services).

F. Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that you wish to amend is accurate and complete or other special circumstances apply.

G. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable fee based on our cost of providing this accounting.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around our facilities and on our Internet site. You also may obtain any new notice by contacting the Privacy Office.

VII. Privacy Office

You may contact the Privacy Office at:

Robert Moran
Director of Operations
Community Health Care, Inc.
P.O. Box 597
Bridgeton, New Jersey 08302
(856) 451-4700
Email: MoranR@SJHS.com

I hereby acknowledge that I have received the Community Health Care, Inc. Notice of Privacy Practices:

_____ _____

(Name) (Date)

(Chaperoned programs only. Please sign below also and return lower portion to your program.)

I hereby acknowledge that I have received the Community Health Care, Inc. Notice of Privacy Practices:

_____ _____

(Name) (Date)

Department of Children and Families
Office of Licensing

INFORMATION TO PARENTS

Under provisions of the *Manual of Requirements for Child Care Centers (N.J.A.C. 3A:52)*, every licensed child care center in New Jersey must provide to parents of enrolled children written information on parent visitation rights, State licensing requirements, child abuse/neglect reporting requirements and other child care matters. The center must comply with this requirement by reproducing and distributing to parents and staff this written statement, prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families. In keeping with this requirement, the center must secure every parent and staff member's signature attesting to his/her receipt of the information.

Our center is required by the State Child Care Center Licensing law to be licensed by the Office of Licensing (OOL), Child Care & Youth Residential Licensing, in the Department of Children and Families (DCF). A copy of our current license must be posted in a prominent location at our center. Look for it when you're in the center.

To be licensed, our center must comply with the Manual of Requirements for Child Care Centers (the official licensing regulations). The regulations cover such areas as: physical environment/life-safety; staff qualifications, supervision, and staff/child ratios; program activities and equipment; health, food and nutrition; rest and sleep requirements; parent/community participation; administrative and record keeping requirements; and others.

Our center must have on the premises a copy of the Manual of Requirements for Child Care Centers and make it available to interested parents for review. If you would like to review our copy, just ask any staff member. Parents may view a copy of the Manual of Requirements on the DCF website at http://www.nj.gov/dcf/providers/licensing/laws/CCCmanual.pdf or obtain a copy by sending a check or money order for $5 made payable to the "Treasurer, State of New Jersey", and mailing it to: NJDCF, Office of Licensing, Publication Fees, PO Box 657, Trenton, NJ 08646-0657.

We encourage parents to discuss with us any questions or concerns about the policies and program of the center or the meaning, application or alleged violations of the Manual of Requirements for Child Care Centers. We will be happy to arrange a convenient opportunity for you to review and discuss these matters with us. If you suspect our center may be in violation of licensing requirements, you are entitled to report them to the Office of Licensing toll free at 1 (877) 667-9845. Of course, we would appreciate your bringing these concerns to our attention, too.

Our center must have a policy concerning the release of children to parents or people authorized by parents to be responsible for the child. Please discuss with us your plans for your child's departure from the center.

Our center must have a policy about administering medicine and health care procedures and the management of communicable diseases. Please talk to us about these policies so we can work together to keep our children healthy.

Our center must have a policy concerning the expulsion of children from enrollment at the center. Please review this policy so we can work together to keep your child in our center.

Parents are entitled to review the center's copy of the OOL's Inspection/Violation Reports on the center, which are available soon after every State licensing inspection of our center. If there is a licensing complaint investigation, you are also entitled to review the OOL's Complaint Investigation Summary Report, as well as any letters of enforcement or other actions taken against the center during the current licensing period. Let us know if you wish to review them and we will make them available for your review or you can view them online at https://data.nj.gov/childcare_explorer.

Our center must cooperate with all DCF inspections/investigations. DCF staff may interview both staff members and children.

Our center must post its written statement of philosophy on child discipline in a prominent location and make a copy of it available to parents upon request. We encourage you to review it and to discuss with us any questions you may have about it.

Our center must post a listing or diagram of those rooms and areas approved by the OOL for the children's use. Please talk to us if you have any questions about the center's space.

Our center must offer parents of enrolled children ample opportunity to assist the center in complying with licensing requirements; and to participate in and observe the activities of the center. Parents wishing to participate in the activities or operations of the center should discuss their interest with the center director, who can advise them of what opportunities are available.

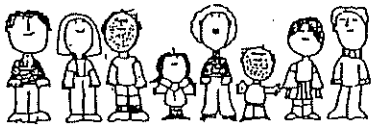
Parents of enrolled children may visit our center at any time without having to secure prior approval from the director or any staff member. Please feel free to do so when you can. We welcome visits from our parents. Our center must inform parents in advance of every field trip, outing, or special event away from the center, and must obtain prior written consent from parents before taking a child on each such trip.

Our center is required to provide reasonable accommodations for children and/or parents with disabilities and to comply with the New Jersey Law Against Discrimination (LAD), P.L. 1945, c. 169 (N.J.S.A. 10:5-1 et seq.), and the Americans with Disabilities Act (ADA), P.L. 101-336 (42 U.S.C. 12101 et seq.). Anyone who believes the center is not in compliance with these laws may contact the Division on Civil Rights in the New Jersey Department of Law and Public Safety for information about filing an LAD claim at (609) 292-4605 (TTY users may dial 711 to reach the New Jersey Relay Operator and ask for (609) 292-7701), or may contact the United States Department of Justice for information about filing an ADA claim at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Our center is required, at least annually, to review the Consumer Product Safety Commission (CPSC), unsafe children's products list, ensure that items on the list are not at the center, and make the list accessible to staff and parents and/or provide parents with the CPSC website at https://www.cpsc.gov/Recalls. Internet access may be available at your local library. For more information call the CPSC at (800) 638-2772.

Anyone who has reasonable cause to believe that an enrolled child has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect, or exploitation by any adult, whether working at the center or not, is required by State law to report the concern immediately to the *State Central Registry Hotline, toll free at (877) NJ ABUSE/(877) 652-2873.* Such reports may be made anonymously. Parents may secure information about child abuse and neglect by contacting: DCF, Office of Communications and Legislation at (609) 292-0422 or go to www.state.nj.us/dcf/.

Kids' Center



Dear Parents,

In keeping with New Jersey's Child Care Licensing requirements, we are obliged to provide you, as the parent of a child enrolled in our center, with this informational statement.

The statement highlights, among other things: your right to visit and observe our center at any time without having to secure prior permission ; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Division of Youth and family Services (DYFS).

Please read this statement carefully and, if you have questions, please feel free to contact me at:

856-447-4673 option #5

Sincerely,

Eric DeJong

Site Coordinator

Please complete and return this portion to the center. (Please Print)

Name of Child: _____

Name of Parent\Guardian: _____

I have read and received a copy of the Information to Parents statement prepared by the Bureau of Licensing in the Division of Youth and Family Services.

Signature: _____ Date: _____

Downe Township Elementary School

220 Main Street Box 809 Newport, NJ 08345 (856) 447-4673 option # 5

POLICY ON THE RELEASE OF CHILDREN

Each child may be released only to the child's parent(s) or person(s) authorized by the parent(s) to take the child from the center and to assume responsibility for the child in an emergency if the parent(s) cannot be reached.

If a non-custodial parent has been denied access, or granted limited access, to a child by a court order, the center shall secure documentation to that effect; maintain a copy on file, and comply with the terms of the court order.

If the parent(s) or person(s) authorized by the parent(s) fails to pick up a child at the time of the center's daily closing, the center shall ensure that:

1. The child is supervised at all times;
2. Staff members attempt to contact the parent(s) or person(s) authorized by the parent(s); and
3. An hour or more after closing time, and provided that other arrangements for releasing the child to his/her parent(s) or person(s) authorized by the parent(s), have failed and the staff member(s) cannot continue to supervise the child at the center, the staff member shall call the *24-hour State Central Registry Hotline 1-877-NJ-ABUSE (1-877-652-2873)* to seek assistance in caring for the child until the parent(s) or person(s) authorized by the child's parent(s) is able to pick-up the child.

If the parent(s) or person(s) authorized by the parent(s) appears to be physically and/or emotionally impaired to the extent that, in the judgment of the director and/or staff member, the child would be placed at risk of harm if released to such an individual, the center shall ensure that:

1. The child may not be released to such an impaired individual;
2. Staff members attempt to contact the child's other parent or an alternative person(s) authorized by the parent(s); and
3. If the center is unable to make alternative arrangements, a staff member shall call the *24-hour State Central Registry Hotline 1-877-NJ-ABUSE (1-877-652-2873)* to seek assistance in caring for the child.

For school-age child care programs, no child shall be released from the program unsupervised except upon written instruction from the child's parent(s).

Policy on the Management of Communicable Diseases

If a child exhibits any of the following symptoms, the child should not attend the center. If such symptoms occur at the center, the child will be removed from the group, and parents will be called to take the child home.

- Severe pain or discomfort
- Acute diarrhea
- Episodes of acute vomiting
- Elevated oral temperature of 101.5 degrees Fahrenheit
- Lethargy
- Severe coughing
- Yellow eyes or jaundiced skin
- Red eyes with discharge
- Infected, untreated skin patches
- Difficult or rapid breathing
- Skin rashes in conjunction with fever or behavior changes
- Skin lesions that are weeping or bleeding
- Mouth sores with drooling
- Stiff neck

Once the child is symptom-free, or has a health care provider's note stating that the child no longer poses a serious health risk to himself/herself or others, the child may return to the center unless contraindicated by local health department or Department of Health.

EXCLUDABLE COMMUNICABLE DISEASES

A child or staff member who contracts an excludable communicable disease may not return to the center without a health care provider's note stating that the child presents no risk to himself/herself or others.

Note: If a child has chicken pox, a note from the parent stating that all sores have dried and crusted is required.

If a child is exposed to any excludable disease at the center, parents will be notified in writing.

COMMUNICABLE DISEASE REPORTING GUIDELINES

Some excludable communicable diseases must be reported to the health department by the center. The Department of Health's Reporting Requirements for Communicable Diseases and Work-Related Conditions Quick Reference Guide, a complete list of reportable excludable communicable diseases, can be found at:

http://www.nj.gov/health/cd/documents/reportable_disease_magnet.pdf.

Quick Reference

Reporting Requirements for Communicable Diseases and Work-Related Conditions

(see New Jersey Administrative Code Title 8, Chapters 57 and 58)

Communicable Disease Service Disease Reporting Requirements and Regulations can be viewed at: http://nj.gov/health/cd/reporting.shtml

Health care providers required to report: physicians, advanced practice nurses, physician assistants, and certified nurse midwives.

Administrators required to report: persons having control or supervision over a health care facility, correctional facility, school, youth camp, child care center, preschool, or institution of higher education.

Laboratory directors: For specific reporting guidelines, see NJAC 8:57-1.7.

CONFIRMED or SUSPECT CASES TELEPHONE IMMEDIATELY to the LOCAL HEALTH DEPARTMENT

- Anthrax
- Botulism
- Brucellosis
- Diphtheria
- Foodborne intoxications (including, but not limited to, ciguatera, paralytic shellfish poisoning, scombroid, or mushroom poisoning)
- , invasive disease
- Hantavirus pulmonary syndrome
- Hepatitis A, acute
- Influenza, novel strains only
- Measles
- Meningococcal invasive disease
- Outbreak or suspected outbreak of illness, including, but not limited to, foodborne, waterborne or nosocomial disease or a suspected act of bioterrorism
- Pertussis
- Plague
- Poliomyelitis
- Rabies (human illness)
- Rubella
- SARS-CoV disease (SARS)
- Smallpox
- Tularemia
- Viral hemorrhagic fevers (including, but not limited to, Ebola, Lassa, and Marburg viruses)

Cases should be reported to the local health department where the patient resides. If patient residence is unknown, report to your own local health department. Contact information is available at: localhealth.nj.gov.

If the individual does not live in New Jersey, report the case to the New Jersey Department of Health at: 609-826-5964.

In cases of immediately reportable diseases and other emergencies - if the local health department cannot be reached - the New Jersey Department of Health maintains an emergency after hours phone number: 609-392-2020.

July 2013
www.nj.gov/health/cd

REPORTABLE WITHIN 24 HOURS OF DIAGNOSIS to the LOCAL HEALTH DEPARTMENT

- Amoebiasis
- Animal bites treated for rabies
- Arboviral diseases
- Babesiosis
- Campylobacteriosis
- Cholera
- Creutzfeldt-Jakob disease
- Cryptosporidiosis
- Cyclosporiasis
- Diarrheal disease (child in a day care center or a foodhandler)
- Ehrlichiosis
- , shiga toxin producing strains (STEC) only
- Giardiasis
- Hansen's disease
- Hemolytic uremic syndrome, post-diarrheal
- Hepatitis B, including newly diagnosed acute, perinatal and chronic infections, and pregnant women who have tested positive for Hep B surface antigen
- Influenza-associated pediatric mortality
- Legionellosis
- Listeriosis
- Lyme disease
- Malaria
- Mumps
- Psittacosis
- Q fever
- Rocky Mountain spotted fever
- Rubella, congenital syndrome
- Salmonellosis
- Shigellosis
- , with intermediate-level resistance (VISA) or high-level-resistance (VRSA) to vancomycin only
- Streptococcal disease, invasive group A
- Streptococcal disease, invasive group B, neonatal
- Streptococcal toxic shock syndrome
- , invasive disease
- Tetanus
- Toxic shock syndrome (other than Streptococcal)
- Trichinellosis
- Typhoid fever
- Varicella (chickenpox)
- Vibriosis
- Viral encephalitis
- Yellow fever
- Yersiniosis

REPORTABLE DIRECTLY to the NEW JERSEY DEPARTMENT OF HEALTH

Hepatitis C, acute and chronic, newly diagnosed cases only
Written report within 24 hours

HIV/AIDS
609-984-5940 or 973-648-7500
Written report within 24 hours

- AIDS
- HIV infection
- Child exposed to HIV perinatally

Sexually Transmitted Diseases
609-826-4869
Report within 24 hours

- Chancroid
- Chlamydia, including neonatal conjunctivitis
- Gonorrhea
- Granuloma inguinale
- Lymphogranuloma venereum
- Syphilis, all stages and congenital

Tuberculosis (confirmed or suspect cases)
609-826-4878
Written report within 24 hours

Occupational and Environmental Diseases, Injuries, and Poisonings
609-826-4920
Report within 30 days after diagnosis or treatment

- Work-related asthma (possible, probable, and confirmed)
- Silicosis
- Asbestosis
- Pneumoconiosis, other and unspecified
- Extrinsic allergic alveolitis
- Lead, mercury, cadmium, arsenic toxicity in adults
- Work-related injury in children (< age 18)
- Work-related fatal injury
- Occupational dermatitis
- Poisoning caused by known or suspected occupational exposure
- Pesticide toxicity
- Work-related carpal tunnel syndrome
- Other occupational disease

H5697

EXPULSION POLICY

NAME OF CENTER: _____

Unfortunately, there are sometimes reasons we have to expel a child from our program either on a short term or permanent basis. We want you to know we will do everything possible to work with the family of the child(ren) in order to prevent this policy from being enforced.

The following are reasons we may have to expel or suspend a child from this center:

IMMEDIATE CAUSES FOR EXPULSION:

- The child is at risk of causing serious injury to other children or himself/herself.
- Parent threatens physical or intimidating actions toward staff members.
- Parent exhibits verbal abuse to staff in front of enrolled children

PARENTAL ACTIONS FOR CHILD'S EXPULSION:

- Failure to pay/habitual lateness in payments.
- Failure to complete required forms including the child's immunization records.
- Habitual tardiness when picking up your child.
- Verbal abuse to staff.
- Other (explain):

CHILD'S ACTIONS FOR EXPULSION:

- Failure of child to adjust after a reasonable amount of time.
- Uncontrollable tantrums/ angry outbursts.
- Ongoing physical or verbal abuse to staff or other children.
- Excessive biting.
- Other (explain):

SCHEDULE OF EXPULSION:

If after the remedial actions above have not worked, the child's parent/guardian will be advised verbally and in writing about the child's or parent's behavior warranting an expulsion. An expulsion action is meant to be a period of time so that the parent/ guardian may work on the child's behavior or to come to an agreement with the center. The parent/guardian will be informed regarding the length of the expulsion period and the expected behavioral changes required in order for the child or parent to return to the center. The parent/guardian will be given a specific expulsion date that allows the parent sufficient time to seek alternate child care (approximately one to two weeks' notice depending on risk to other children's welfare or safety).Failure of the child/parent to satisfy the terms of the plan may result in permanent expulsion from the center.

A CHILD WILL NOT BE EXPELLED IF A PARENT/GUARDIAN:

- Made a complaint to the Office of Licensing regarding a center's alleged violations of the licensing requirements.
- Reported abuse or neglect occurring at the center.
- Questioned the center regarding policies and procedures.
- Without giving the parent sufficient time to make other child care arrangements.

PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION:

- Try to redirect child from negative behavior.
- Reassess classroom environment, appropriateness of activities, supervision.
- Always use positive methods and language while disciplining children.
- Praise appropriate behaviors.
- Consistently apply consequences for rules.
- Give the child verbal warnings.
- Give the child time to regain control.
- Document the child's disruptive behavior and maintain confidentiality.
- Give the parent/guardian written copies of the disruptive behavior that might lead to expulsion.
- Schedule a conference including the director, classroom staff, and parent/guardian to discuss how to promote positive behaviors.
- Give the parent literature of other resources regarding methods of improving behavior.
- Recommend an evaluation by professional consultation on premises.
- Recommend an evaluation by local school district study team.

Community Health Care, Inc.
School Based Programs
KIDS' CENTER
School Age Child Care
REGISTRATION FORM

Student Name: _____ PHONE #: _____

Birth Date : _____ Grade: _____ Homeroom Teacher: _____

Home Address: _____

Please circle all days you wish your child to attend the Kids' Center AFTERNOON School Age Child Care Program:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

or

AS NEEDED

* Please Note: Children signed up for Kids' Centers SACC on an "AS NEEDED" basis MUST have a note sent to school by the parent or guardian the day you wish your child to attend. If the child does not have a written note, they will not be able to attend.

Persons Authorized To Pick Child\Children From Kids' Center and act in my behalf in the event of an Emergency: (Other than PARENT)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Mother's Name: _____ Home Phone: _____ Cell: _____

Mother's Employer: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____ Cell: _____

Father's Employer: _____ Work Phone : _____

**Custodial Information:
If a non-custodial parent is not included among those persons authorized by the custodian parent to pick up the child, please explain below and attach a copy of the appropriate documents.

*****If there is a CUSTODY arrangement we MUST have a copy.

(Please complete the reverse side of this form and complete all signature sections)

BY MY SIGNATURE, I ATTEST TO THE FOLLOWING:

1. That the information listed on the reverse side of this form is true and correct.

2. That in the event of a medical emergency, I authorize the Kids' Center to seek emergency medical care for my child as deemed necessary by the Director.

3. That I have received the "Information to Parents Document".

4. That I have received the Kids' Center Handbook.

5. I consider my child, _____, in good health is physically fit and is able to participate in all Kids' Center School Age Child Care activities.

6. I give permission for my child/children to be photographed for program use only.

7. I give permission for my child/children to leave the PM SACC Program and help teachers or support staff. YES NO

_____ _____
Parent/Guardian Signature* Date

*****Custodial Information:
If a non-custodial parent is not included among those persons authorized by the custodian parent to pick up the child, please explain below and attach a copy of the appropriate documents. (Court Order)

_____

MEDICAL INFORMATION

CHILD'S PHYSICIAN'S NAME: _____ Office Phone: _____

Physician's Address: _____

Does your child have any allergies or medical conditions? If so please list:

Is your child allergic to bee stings or have any food allergies? NO YES*
*If yes, please describe the allergy and what should be done:

Does your child take any medications? NO YES*
*If yes, please list:

Is there any information you can share with us that will be helpful for us to know about your child? If so, please list:

**Should there be any changes Please contact the Kids' Center Office immediately.

(856) 447-4673 Option #5

COMPLETE CARE, INC.

POLICY AND PROCEDURE MANUAL

Subject: TV/Video Game Viewing/Playing Policy PAGE: 01 OF 01

EFFECTIVE DATE: 1-1-2016

Department: School Based - SACC DATED: 1-1 2016

Distribution: Kids' Center Staff, Complete Care Director

Policy:

1. Kids' Center Staff will ensure use of TV/computer/video is educational/instructional and age/developmentally appropriate, and not used as a substitute for planned activities for passive viewing.

2. For Special Needs students, Kids' Center staff will comply with student's Individualized Education Plan.

Responsibility

A. Director
B. SACC Staff

1. Procedure

A. All SACC Staff will monitor TV/computer/video viewing by students during Kids' Center PM SACC Program.

B. Staff Director will be responsible for reviewing IEP for special needs students and communicated pertinent recommendations to staff.

Disciplinary Policy

Methods of guidance and discipline used at Kids' Center SACC will be positive, consistent and appropriate for the child's age and developmental capabilities.

Verbal Warning -Students engaging in behaviors that are in violation of the rules of conduct or deemed inappropriate will receive a verbal warning. Staff will identify and discuss with students the infraction and reinforce behavioral expectations.

Written Warning - Parents will receive written documentation of the incident. Kids' Center staff will discuss the nature of the infraction with parent when they are presented with the written warning. This will give the parent an opportunity to speak with the child and review the Kids' Center rules of conduct.

Second Written Warning - Parents will again receive written documentation of the incident. Kids' Center staff will discuss the nature of the infraction with parent when they are presented with the written warning. Parents will be advised that further infractions may lead to a suspension from the program.

Continued infractions, inappropriate behavior may result in suspension from the Kids' Center program. Suspensions may range from one day to one week based on the nature of the infraction. It will be required that a suspended child attend a conference with a parent and the Kids' Center Coordinator prior to returning to the program

Additionally, Kids' Center reserves the right to expel a student for an indefinite period of time for ongoing conduct issues or inappropriate behaviors that create an unsafe or inhospitable environment for our students.

PARENT
RECEIPT OF INFORMATION:

☐ Information to Parents Document

☐ Policy on the Release of Children

☐ Policy on Methods of Parental Notification
(Applicable only if a method other than a phone call is used to notify parents of an injury to a child's head, a bite that breaks the skin, a fall from a height, or an injury requiring professional medical attention.)

☐ Policy on Communicable Disease Management

☐ Expulsion Policy

☐ Policy on the Use of Technology and Social Media

I have read and received a copy of the information/policies listed above.

Child(ren)'s Name: _____

Parent/Guardian's Name: _____

_____ _____
Signature Date