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Maple Street Clinic  
109 E. Maple, Gillespie, IL 62033  
217-839-1526 ~ Medical/Behavioral  
217-839-1538 ~ FAX



Morgan Street Clinic  
1115 Morgan St., Carlinville, IL 62626  
Medical/Behavioral ~ 217-854-3692  
FAX ~ 217-930-2293  
Dental ~ 217-854-6823

Columbian Blvd. Dental Clinic ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ 217-250-2365 (fax)  
St. Francis Way Clinic ~ 805 St. Francis Way ~ Litchfield, IL 62056 ~ 217-250-2380 (p) ~ 217-250-2385 (fax)  
Oakland Avenue Clinic ~ 205 Oakland Ave ~ Carlinville, IL 62626 ~ 217-854-3223 (p) ~ 217-854-3225 (fax)

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Dear Parent/Guardian:

As you may know, we provide school-based dental services for students in your child's school district. There are eligibility guidelines regarding these services. Eligible students include those who have Medicaid or a Medicaid Managed Care as primary insurance or those who have no dental insurance.

Attached to this cover letter is a Registration Form. Please complete this form if you are interested in scheduling services for your child at their school.

If your child has private dental insurance and you would like to schedule an appointment at one of our offices, please contact one of our dental clinics.

Maple Street Dental Clinic, Gillespie: 217-839-4110  
Morgan Street Dental Clinic, Carlinville: 217-854-3692  
Columbian Boulevard Dental Clinic, Litchfield: 217-250-2360

Sincerely,

*School Linked Health Center Dental Staff*  
Macoupin County Public Health Department

## ATTESTATION OF INSURANCE COVERAGE

Updated: 4/10/2023

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Maple Street Clinic, Morgan Street Clinic, Columbian Blvd Dental Clinic, Macoupin County Public Health Department, and the Illinois Department of Healthcare and Family Services have arranged for certain dental, medical and counseling services for eligible children. Services may include a school or sports physical, immunizations, sick/urgent care, dental care, and counseling.

### I hearby declare that:

- I do not have insurance coverage of any kind including, but not limited to, Commercial Insurance, Medicare, or Medicaid.
- I understand that my lack of insurance does not prevent me from receiving services.
- I understand that I will not be charged for services related to the School-Based/Linked Health Center Program due to lack of insurance.
- I agree to inform MCPHD if I am enrolled with an insurance company within the next 30 days.

I affirm that all the information given on this is true, complete, and accurate to the best of my knowledge.

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_

Patient or Parent/Guardian Signature: \_\_\_\_\_

**Maple Street Clinic**

109 E. Maple, Gillespie, IL 62033  
 217-839-1526 – Medical/Behavioral  
**217-839-1538 - FAX**  
 217-839-4110 – Dental

**Macoupin County**

Public Health Department

**Morgan Street Clinic**

1115 Morgan Street, Carlinville, IL 62626  
 217-854-3692 – Medical/Behavioral  
**217-930-2293 – FAX**  
 217-854-6823 – Dental

**Oakland Ave Clinic** ~ 205 Oakland Ave ~ Carlinville, IL 62626 ~ 217-930-2355 (p) ~ **217-930-2116 (fax)**

**Columbian Blvd. Dental Clinic** ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ **217-250-2365 (fax)**

**St. Francis Way Clinic** ~ 805 St. Francis Way ~ Litchfield, IL 62056 ~ 217-250-2380 (p) ~ **217-250-2385 (fax)**

Dear Parents,

A convenient program will soon be available in your child's school. Macoupin County Health Centers, Macoupin County Public Health Department, and the Illinois Department of Healthcare and Family Services have been arranged for certain dental, medical and counseling services for eligible children. Services may include a school or sports physical, immunizations, sick/urgent care, dental care, and counseling. In order for your child to receive these services, please fill out this form and return it to your child's school nurse. If you or any family member are in need of these services, they are also available for adults at our facilities in Carlinville, Gillespie or Litchfield.

Please print IN INK and answer ALL the following questions:

SCHOOL: \_\_\_\_\_ TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: M / F

ADDRESS: \_\_\_\_\_ CITY/ZIP \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

GENDER IDENTITY: ☐ Male ☐ Female ☐ Female to Male ☐ Genderqueer ☐ Male to Female ☐ Choose not to disclose  
☐ Other (please describe): \_\_\_\_\_

SEXUAL ORIENTATION: ☐ Straight – heterosexual ☐ Bisexual ☐ Choose not to disclose ☐ Lesbian, gay, or homosexual ☐ Don't Know  
☐ Something else (please describe): \_\_\_\_\_

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Many HOUSING: ☐ Public Housing ☐ Rent ☐ Own ☐ Other

RACE: Please check all that apply for your child: ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ White ☐ Other

How many people live in your family unit? \_\_\_\_\_ What is your estimated annual household gross income? \_\_\_\_\_

If patient is a child, do they qualify for free/reduced school lunch? ☐ Yes ☐ No

Does the patient have (check all that apply): ☐ Private Insurance ☐ Medicaid/Medicaid Managed Care ☐ No Insurance

• If Medicaid/Medicaid Managed Care, what is the recipient number (9 digits) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

• If Private or Medicare/Advantage Insurance,

Company Name: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

**HEALTH HISTORY**

Has your child had any serious health problems? ☐ Yes ☐ No If YES, please explain \_\_\_\_\_

Does your child have any allergies? ☐ Yes ☐ No If YES, please explain \_\_\_\_\_

Is your child taking any medications currently? ☐ Yes ☐ No If YES, please list \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

The above is true and correct to the best of my knowledge. All clients have the right to treatment by Macoupin County Public Health Department and Macoupin County Health Centers without discrimination to age, race, color, religion, sex, sexual orientation, or national origin. I accept full responsibility for my care and treatment and release MCPHD and MCHC and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment. I authorize Macoupin County Public Health and Macoupin County Health Centers to provide service to me and to release necessary information to bill, process, and receive payment of Medical/Behavioral/Dental Benefits (private insurance, Medicare, Medicaid, etc.), for Professional Services rendered. I give permission for IDPH, QA audits to be performed and providers to return to check my child's sealants and for the school nurse and providers access to the child's dental record or medical record.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Available services include, but are not limited to:**

- Physical examination, health assessments, screening for health problems
- Diagnosis and treatment of acute illness and injury
- Immunizations, Lead, Hemoglobin, and TB skin tests
- Diagnosis and management of chronic illness
- Health education and promotion. Outreach health promotion/prevention workshops will be offered
- Laboratory tests including throat cultures, complete blood counts, mono spots, etc.
- Wellness promotion including smoking cessation, nutrition, weight management
- Reproductive health care including: gynecological examinations with PAP smears, STD education, testing and treatment, HIV/ AIDS education, counseling/testing, and contraceptive services
- Mental Health counseling services
- Dental examination and treatment by a licensed dentist or Public Health Dental Hygienist
- Referrals to other linkage agencies for services not provided at the School Health Center

**Please select the service(s) you (parent or legal guardian) give consent for:**

**Dental**

- ☐ All services below
- ☐ Sealants
- ☐ Fluoride
- ☐ Prophylaxis (cleaning)
- ☐ Dental X-rays
- ☐ Exams & treatment
- ☐ Decline services

**Medical**

- ☐ All services below
- ☐ Immunizations
- ☐ School/sports physicals
- ☐ Treatment for acute illness/injury
- ☐ Reproductive health care
- ☐ Decline services

**Mental Health**

- ☐ Counseling
- ☐ Decline services

Please give my child vaccinations that will make him/her compliant with Illinois State School Requirements.

Parent/Guardian \_\_\_\_\_

In addition to the Illinois State School Required Immunizations, please give my child vaccinations that are recommended by the American Pediatric Association. This authorization does not include the COVID-19 vaccine.

Parent/Guardian \_\_\_\_\_

By signing below, I consent for the above selected dental services to be provided by a Public Health Dental Hygienist.

I understand the services received are meant for those who otherwise would not have access to services. These services do not take the place of a regular dental examination given at a primary dental office. I understand I will still need a thorough comprehensive exam by a licensed dentist.

Parent/Guardian \_\_\_\_\_

**Parental Consent PUBLIC ACT 100-378 consent by Minors to Health Care Services Act**

The above-named student has my consent to receive services offered by Macoupin County Public Health Department and Macoupin County Health Centers. I have been informed of and understand the scope of services which may be provided to the student. I understand that under Illinois law, a minor age twelve (12) and over has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. I understand that if my child is 12 or older and were to receive mental health/substance abuse services at Macoupin County Public Health Department and Macoupin County Health Centers, he/she may receive up to eight (8) therapy sessions without my consent. I am aware that a separate parental consent form will need to be signed for substance abuse services. By law, a child under the age of twelve (12) will not be allowed to receive mental health/substance abuse services without parental consent.

I also consent to the release of relevant health information to the Macoupin County Health Department and Macoupin County Health Centers in order to facilitate evaluation of my child's health needs. I further authorize the School-Linked Health Center to release information regarding my child's treatment to third-party payers or others for the purposes of billing, program management, and evaluation in accordance with federal and state laws and regulations regarding confidentiality. I further authorize my child's school district to release to the School-Linked Health Center regarding my child's address and phone number for the purpose of maintaining the School-Linked Health Center's database.

I understand that I may revoke this consent in writing at any time, but that revoking this consent will not cancel what was done before I revoked the consent. I also understand that I have the right to refuse services at any time.

Signature of Parent/Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_