Dear Parent/guardian:

This can be a very challenging and confusing time for everyone during the pandemic. This letter is to inform you that our Student Assistance Program at Big Spring School District is still operating at this time. Alternative procedures have been put in place to allow us to continue to offer supportive services to our students and families while maintaining the social distancing guidelines in Pennsylvania, ensuring everyone's safety. As described in the paperwork included in this correspondence, one of the primary goals of SAP is to provide support to students experiencing academic, behavioral, and/or emotional difficulties that are impacting their ability to be successful in the academic setting. Included in this packet are various forms that need to be approved by the parent/guardian and student in order for the process to continue. These forms include:

- Big Spring Parent/Guardian Consent Form
- PennState Health Parent Consent form (for Mental Health Assessment by Teenline)
- PennState Health Student Consent Form (for Mental Health Assessment by Teenline)
- Parent Input Form
- SAP Informational Brochure

At this time, we are accepting approval for the process to continue by allowing the Parent/Guardian Consent and PennState Health Student Consent to be signed and scanned back via e-mail OR by sending an email indicating that you have read the materials and are approving for your child to speak to our Teenline liaison, Maria DaGaetano or to Angelina Romano, Cumberland-Perry Drug and Alcohol liaison. We will also need an email from the student confirming agreement to participate since this is a voluntary program. Additionally, please provide any information about your own observations of your child's behavior on the Parent input form that you believe will be beneficial to know to get an accurate picture of your concerns during this stressful time. This information can be described in an email if you are not able to print and scan the attached forms. If access to email is difficult, we can arrange for the forms to be sent in the mail and returned in the post mail.

One other significant change in the Student Assistance Process at this time is that the assessments will be conducted over the phone instead of in-person as it would occur during the normal school year. To help facilitate this process, we will need the best phone number of where the clinician can reach you and your child to conduct the assessment at home. Additionally, the assessment needs to occur when the parent is in the household, but also when the student can have some privacy to openly discuss concerns with the clinician from Teenline and/or Cumberland/Perry D&A Commission, privately. It is hoped that the assessment can occur on the off days for students. (i.e, If they are cohort A, try to meet with them on Tuesday or Thursday) In continuing with the practice of the SAP program, the clinician will follow-up with the parent/guardian to provide a summary of the child's assessment and include recommendations to meet the needs of the child.

Should you have any further questions, please contact Sherri Webber-Mains at SAPteamhs@bigspring.k12.pa.us, smains@bigspring.k12.pa.us or (717) 776-2428. Thank you for your time and assistance as we work through this challenging time together by providing support to your child.

Big Spring High School Student Assistance Team

Parental Observations for: _____

Please check the appropriate responses in each section and add comments with specific examples wherever possible.

A. Academic Performance: My student's…

___ Grade / Progress reports are not as good as before.
___ Interest in classes and assignments has declined.
___ Time spent on homework has decreased.
___ Attention span is short.
___ Short-term memory is poor.
___ Extremely perfectionistic.

B. School Attendance: My student is...

___ frequently absent / tardy, with my knowledge.
___ frequently absent / tardy without my knowledge.
___ often sick / difficult to awaken.
___ often going to guidance.

C. Disruptive behavior:

	At home	School
Defiance, re:rules	___	___
Blaming others	___	___
Fighting	___	___
Cheating	___	___
Anger, sudden outbursts	___	___
Obscene language/gestures	___	___
Attention seeking	___	___
Crying, unexplainable	___	___
Extreme negativism	___	___
Hyperactivity, nervousness	___	___
Self-Abusive	___	___

D. Changes in behavior:

___ Change in friends
___ Erratic behavior
___ Sudden popularity
___ Defensive
___ Disoriented
___ Talks freely of drug / alcohol use
___ Inappropriate responses
___ Depression, withdrawn
___ Expresses worthlessness, helplessness
___ Expresses desire to die, harm self

E. Physical Symptoms: My student…

___ sleeps at unusual times / for extremely long periods of time.
___ is frequently ill.
___ is unsteady on his / her feet.
___ is fatigued / lethargic.
___ has slurred speech.
___ has smelled of alcohol / marijuana.
___ has had glassy / bloodshot eyes.
___ has deteriorated in his / her physical appearance.
___ has lost a large amount of weight without explanation.

(For the above symptoms, please indicate the frequency of your observations.)

F. Extracurricular Activities:

- My son / daughter has never been involved in school activities, but…
  - ___ continues to be involved in non-school activities.
  - ___ has stopped participating in other activities.
- My son / daughter has always been involved in school activities…
  - ___ and is continuing to be involved.
  - ___ and has become disinterested.
  - ___ and has dropped out.

G. Home: My son / daughter has...

___ been affected by problems at home that do not involve them.
___ threatened or tried to run away.
___ seemed unhappy to come home.
___ spent an unusual amount of time alone.

H. Suicide Crisis: My son / daughter has...

___ threatened suicide.
___ made suicidal gestures.
___ been preoccupied with death.
___ committed self-mutilation.

Parent Signature: _____ **Date: _____**

Additional Comments:

Big Spring High School
Parent/Guardian Consent
Student Assistance Team

Dear _____:

Your child, _____, has been referred to the Student Assistance team at the Big Spring High School (SAP). This voluntary program is available to offer supportive services to students experiencing academic, behavioral, and/or emotional difficulties that may pose barriers to school success, including student attendance and engagement.

Students can be referred to the SAP by parents/guardians, school personnel, peers or self-referrals. The SAP team is comprised of specially trained teachers, administrators, school counselors and a mental health and/or drug & alcohol consultant(s). Please review the attached brochure for additional information about the members that participate on the SAP Team this school year. Our mental health consultant is from Teenline of Penn State Health Holy Spirit Medical Center. Our drug & alcohol consultant is from Cumberland- Perry Drug & Alcohol Commission. Our goal is to work with you and to offer support and recommendations for your son/daughter. Where barriers are beyond the scope of the school, the team can provide information so families may access community resources.

You are a vital part of the team and the SAP team values the input and involvement of parent/guardian in this process. A team member is ready to talk with you about the referral and obtain information about your child. With your permission, our Student Assistance Team will initiate the SAP process which includes sending checklists to the teachers who work with your child to collect objective information and meet with your son/daughter to discuss the referral and results of the checklists. A Teenline and/or Cumberland-Perry Drug and Alcohol Counselor may meet with your child during the school day to conduct an assessment and provide support. The school may release relevant information from your child's records to those individuals involved in his/her assessment and any related service providers that may be recommended to provide support to your child after the assessment.

Please complete the bottom portion of this letter and return it in the envelope by as soon as possible. If you have any questions about the Student Assistance Program, please call _____, SAP team member, at _____. Thank you for being part of our team.

****

I, _____, agree for my child, _____
Parent Name Student Name

to participate in the Care Team Process at the Big Spring School District and agree to the following:

- A Care team member may send checklists to teachers who work with my child.
- A Care team member may meet with my child to discuss the referral and results of the checklists.
- A Teenline and/or Cumberland-Perry Drug and Alcohol Counselor may meet with my child during the school day to provide services as part of the student assistance/care team program.
- The school may release information from my child's records to those individuals involved in services recommended as part of the student assistance/care team process.

Parent(s)/Guardian Signature: _____ *Date:* _____
Parent Signature

Student Assistance Program

Informed Consent for a Mental Health Assessment - Parent

Your child has been referred to the Student Assistance Program (SAP) at school. SAP is a voluntary process. In the event that the SAP team feels your child could benefit from a mental health assessment, you will be contacted by a SAP team member, and one can be conducted by a Teenline counselor with your written permission. Upon completion of the assessment, the Teenline counselor will contact you to offer recommendations for you to consider. * You can also contact the Teenline counselor ahead of time with questions or concerns. The Teenline counselor *does not* provide ongoing counseling or mental health treatment. Teenline cannot screen students who are already receiving mental health services. **In order for the assessment to take place, Teenline needs your written permission below.**

The assessment is free of charge and will take place during the school day at your child's school. The Teenline counselor will have access to your child's school records to assist in the assessment. All student assistance information will be maintained in the strictest confidence. A written recommendation from the assessment will be provided to the school's SAP team to be placed in their student SAP file. We are providing you with a *Notice of Privacy Practices* for your review. Your signature below also acknowledges you received this information. If you have any questions, please feel free to contact Teenline at 717-763-2345.

Thank you for your cooperation.

*According to Pennsylvania law, a person age of 14 or older has a right to decide how much information is shared and with whom after the assessment.

Parent/Guardian Permission Form

Student's Name: _____ Grade: _____ Date of Birth: _____

Please circle: Yes or No A member of the school's Student Assistance Program (SAP) has explained the SAP process to me and the purpose of the mental health assessment.

Yes or No My child is already receiving mental health services with a treatment provider such as a psychiatrist, therapist, counselor and/or mental health case manager.

_____ I give permission for my son/daughter to participate in a confidential assessment conducted by a Teenline counselor during school hours at my child's school building. I understand that this assessment is conducted as part of the SAP process and a written recommendation will be shared with the SAP Team to be placed in your child's SAP file. It will allow the SAP team to offer recommendations for in-school and out-of-school supports. This information will also be shared with me and my child.

_____ I do not give permission for my son/daughter to participate in a confidential assessment conducted by a Teenline counselor. I understand that should I change my mind, I can contact anyone on the SAP Team.

Parent/Guardian Signature: _____ Date: _____

Phone Number(s): _____

Student Assistance Program
Informed Consent for a Mental Health Assessment - Student

You have been referred to the Student Assistance Program (SAP) at school. SAP is a voluntary process. The SAP team and your parent/guardian feels you could benefit from a mental health assessment and one can be conducted by a Teenline counselor with your written permission. Upon completion of the assessment, the Teenline counselor will talk with you, your parent/guardian and the SAP team to offer recommendations for you to consider. * The Teenline counselor *does not* provide ongoing counseling or mental health treatment. Teenline cannot conduct a mental health assessment if you are already receiving mental health services. **In order for the assessment to take place, Teenline needs your written permission below.**

The Teenline counselor will have access to your school records to assist in the assessment. All student assistance information will be maintained in the strictest confidence. A written recommendation from the assessment will be provided to the school's SAP team to be placed in your student SAP file. We are required by law to disclose information shared that pertains to threats of harm to self, threats of harm toward others and allegations of behavior that may be considered child abuse. We are providing you with a *Notice of Privacy Practices* for your review. Your signature below also acknowledges you received this information. If you have any questions, please feel free to ask the Teenline counselor.

Thank you.
*According to Pennsylvania law, a person age of 14 or older has a right to decide how much information is shared and with whom after the assessment.

Student Permission Form

Name: _____ Grade: _____ Date of Birth: _____

Please circle: Yes or No A member of the school's Student Assistance Program (SAP) has explained the SAP process to me and the purpose of the mental health assessment.

Yes or No I am already receiving mental health services with a treatment provider such as a psychiatrist, therapist, counselor and/or mental health case manager.

_____ I agree to participate in a confidential assessment conducted by a Teenline counselor. I understand that this assessment is conducted as part of the SAP process and the recommendations will be shared with my parent/guardian. A written recommendation from the assessment will be provided to the school's SAP team to be placed in your student SAP file. It will allow the SAP team to offer recommendations for ~~i~~n-school and out-of-school supports. This information will also be shared with me.

_____ I do not agree to participate in a confidential assessment conducted by a Teenline counselor. I understand that should I change my mind, I can contact anyone on the SAP Team.

Student Signature: _____ Date: _____

Penn State Health
Privacy Notice

Effective Date: November 29, 2017

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.

If you have any questions about this Notice, please contact our Privacy Office at (717) 531-2081.

WHO WILL FOLLOW THIS NOTICE:

This Notice describes Penn State Health (PSH) practices and that of any health care professional authorized to enter information into your PSH chart; all departments and units of PSH; any member of a volunteer group we allow to help you while you are being cared for by PSH; all employees, staff, students, trainees, and other PSH personnel; and all of our on- and off-campus community, clinics, and doctors' offices.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at PSH. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by PSH, our on- and off-campus clinics, and doctors' offices. This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- *Make sure that medical information that identifies you is kept private;*
- *Provide this Notice of our legal duties and privacy practices with respect to medical information about you; and*
- *Follow the terms of the Notice that is currently in effect.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:*

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical and other healthcare students, or other PSH personnel who are involved in taking care of you at PSH. For example, a doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at PSH may be billed to, and payment may be collected from you, a health plan, an insurance company, or a third party. For example, we may need to give your health plan information about surgery you received at PSH so that your health plan will pay us or reimburse you for the surgery.

For Health Care Operations: We may use and disclose medical information about you for PSH operations. These uses and disclosures are necessary to run PSH and to make sure that all of our patients receive quality care. For example, we may disclose information to doctors, nurses, technicians, medical and other healthcare students, and other PSH personnel for review and learning purposes.

Health Information Exchanges: We may use and disclose medical information about you electronically through Health Information Exchanges ("HIE"s) to ensure that your healthcare providers outside of PSH have access to your medical information regardless of where you receive care. In addition, PSH personnel may use HIEs to obtain information about care you received from healthcare providers outside of PSH when those providers share your medical information with an HIE. Having immediate access to your medical information through an HIE allows healthcare providers to improve the safety and quality of care they provide to you. Organizations that participate in HIEs may also use medical information for purposes other than treatment as allowable by law. Patients may opt-out of HIEs. PSH will

use reasonable efforts to limit the electronic sharing of medical information for patients who have opted-out. If you wish to opt-out, please request an opt-out form from PSH registration staff.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at PSH.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Business Associates: There are some services provided at PSH through agreements and arrangements with other organizations and individuals not employed by PSH. Examples include companies performing maintenance on medical equipment, and temporary personnel provided by agencies ("Associates"). We may disclose your medical information to these Associates so that they can provide necessary services. We require these associates to agree that they will protect the privacy of your medical information in the same manner that we do.

Fundraising Activities: We may use limited medical information about you to contact you in an effort to seek voluntary donations to support the charitable missions of PSH. We may also disclose limited information to Penn State (which helps PSH seek charitable donations) so that Penn State may contact you in raising money for PSH. If we use or disclose your medical information for fundraising activities, we will provide you the choice to opt-out of those activities. You may also choose to opt back in.

PSH Directory: We may include certain limited directory information about you in the hospital directory while you are a patient at the hospital. Directory information may include your name, location in the hospital, your general condition, and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy. However, you can tell us not to release any part or all of this directory information and we will follow your instructions.

Individuals Involved in Your Care: We may release medical information about you to a friend or family member who is involved in your medical care.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. The use and disclosure for research projects are subject to a special authorization process. This process evaluates a proposed research project and its use of medical information, determining that your medical information will be adequately protected. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project to help them look for patients with specific medical needs, so long as the medical information they review does not leave PSH.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.

SPECIAL SITUATIONS:

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- *To prevent or control disease, injury, or disability.*
- *To report births and deaths.*
- *To report child abuse or neglect.*
- *To report reactions to medications or problems with products.*
- *To notify people of recalls of products they may be using.*
- *To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.*

- *To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.*

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: In connection with a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We may use and disclose medical information in defending or asserting a lawsuit involving your treatment at PSH.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar law enforcement process.

Coroners, Medical Examiners, and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of PSH to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

We may disclose or release other certain types of your medical information but only with your consent, authorization or opportunity to object, unless we are required by law. Specifically, without your authorization, we are expressly prohibited from using or disclosing your medical information for marketing purposes. In addition, we may not sell your medical information without your authorization. We may not use or disclose psychotherapy notes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of medical information, except psychotherapy notes. You must submit your request in writing to Health Information Management. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and obtain a copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by PSH will review your request and the denial. The person conducting the review will NOT be the person who denied your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to add to or refute the information. Your request must be made in writing and submitted to Health Information Management. In addition, you must provide a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to add to or refute information that:

- *Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;*
- *Is not part of the medical information kept by or for PSH;*
- *Is not part of information which you would be permitted to inspect and obtain; or*
- *Is accurate and complete.*

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you to organizations or persons outside PSH. The list will not include disclosures we made to you, disclosures made for purposes of treatment, payment or our operations, or those authorized by you. To request this list or accounting

of disclosures, you must submit your request in writing to the Privacy Office. Your request must state a time period of disclosures to be included, up to six years prior to the date of your request. The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive Notice of a Breach: We will notify you if any of your medical information has been breached.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request, except if you request that we not disclose your medical information to your health plan with respect to healthcare for which you have paid PSH out of pocket, in full. To request restrictions for disclosure to your health plan, you must make your request to registration staff at the time of service. To request all other restrictions, you must make your request in writing to the Privacy Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to ask that we send information to you to an alternate address or by alternate means. We must agree to your request so long as we can easily provide it in the format you requested.

Right to Get This Notice by E-Mail: You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of this Notice. (Please note: If you are interested in communicating with your PSH physician by e-mail, you should read "A Patient's Guide to Electronic Mail," available on our Web site, and at our care facilities.)

You may obtain a copy of this Notice at our Web site, http://hmc.pennstatehealth.org/privacy, or by writing to:

Privacy Office
P.O. Box 850, MC A150
Hershey, PA 17033

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice: We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at PSH. The Notice will contain the effective date on the first page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with PSH or with the Secretary of the Department of Health and Human Services. There will be no retaliation from PSH for filing a complaint. To file a complaint with PSH, you must contact:

Privacy Office
P.O. Box 850, MC A150
Hershey, PA 17033
Phone: (717) 531-2081

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

*Pennsylvania Code requires your written authorization for release of protected health information outside of our hospital. Since that requirement pre-empts HIPAA, you will be asked to sign such an authorization when you register for an inpatient, outpatient, or emergency visit, allowing us to send information to your health insurance company. The statement is included in the consent for treatment and assignment of benefits forms.

Por favor solicite una copia en Español de este Aviso de Privacidad a su representante de admisiones de PSH.

PennState Health