

Delaware Health and Social Services

Division of Public Health

Attachment A

Application for Becoming a State Recognized School-Based Health Center Provider for Contracted Entities

Cover Sheet

Name of Applicant Organization and Tax ID#:																			
Applicant Organization Contact: Name: Phone: Email:																			
School Name(s) and locations (addresses) of SBHC(s):																			
Source of SBHC Program Funding: (check all that apply)	<table><thead><tr><th>Source</th><th>Amount, if known</th></tr></thead><tbody><tr><td><input type="checkbox"/> None</td><td></td></tr><tr><td><input type="checkbox"/> Local/ County Funds</td><td>_____</td></tr><tr><td><input type="checkbox"/> Other health providers</td><td>_____</td></tr><tr><td><input type="checkbox"/> Other State Funds</td><td>_____</td></tr><tr><td><input type="checkbox"/> Private donors/ Organizations</td><td>_____</td></tr><tr><td><input type="checkbox"/> Federal Funds</td><td>_____</td></tr><tr><td><input type="checkbox"/> Other</td><td>_____</td></tr><tr><td><input type="checkbox"/> In-Kind</td><td>_____</td></tr></tbody></table>	Source	Amount, if known	<input type="checkbox"/> None		<input type="checkbox"/> Local/ County Funds	_____	<input type="checkbox"/> Other health providers	_____	<input type="checkbox"/> Other State Funds	_____	<input type="checkbox"/> Private donors/ Organizations	_____	<input type="checkbox"/> Federal Funds	_____	<input type="checkbox"/> Other	_____	<input type="checkbox"/> In-Kind	_____
Source	Amount, if known																		
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<input type="checkbox"/> Local/ County Funds	_____																		
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<input type="checkbox"/> Private donors/ Organizations	_____																		
<input type="checkbox"/> Federal Funds	_____																		
<input type="checkbox"/> Other	_____																		
<input type="checkbox"/> In-Kind	_____																		
Program Description: (Please provide a description of the program and services to be provided.)																			

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Services to be provided:	
	<input type="checkbox"/> Diagnosis and treatment of acute medical conditions <input type="checkbox"/> Identification and referral of chronic conditions <input type="checkbox"/> Mental health counseling and referral. <input type="checkbox"/> Prescribing and/or dispensing of non-Prescription/prescription medications. <input type="checkbox"/> Health education <input type="checkbox"/> Immunizations <input type="checkbox"/> Nutrition counseling, consultation and/or education <input type="checkbox"/> Minor laboratory tests <input type="checkbox"/> Diagnosis and treatment of STDs (subject to School Board approval) <input type="checkbox"/> HIV Testing and Counseling Services (subject to School Board approval) <input type="checkbox"/> Reproductive Health Services (subject to School Board approval) <input type="checkbox"/> Other
<u>ASSURANCES:</u>	
Compliance with DE SBHC Regulations. I have read and agree to comply with the State of Delaware Regulation(s), 18 Del.C. §§3365 & 3571G	<hr/> <p>Signature</p> <hr/> <p>Title</p>

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Cover Sheet cont.

	<hr/> <p>Date</p>
<p>Updating of contact Information:</p> <p>I agree to notify DPH if any of the information provided in this application to become a State Recognized School-Based Health Center Provider changes.</p>	<hr/> <p>Signature</p> <hr/> <p>Date</p>
<p>Date of Provider Application:</p> <p>Application for becoming a State Recognized School-Based Health Center Provider is submitted on _____.</p>	<hr/> <p>Signature</p> <hr/> <p>Date</p>

Please complete Attachment A and B, then submit completed package to:

Division of Public Health
School-Based Health Centers
417 Federal Street
Dover, DE 19901

For Questions call (302) 744-4822