Memorandum of Understanding
Amoskeag Health and Manchester School District
School-Based Health and Behavioral Health Services

This Memorandum of Understanding (MOU) sets forth the terms and understanding between Amoskeag Health and the Manchester School District. This Agreement is made by and between Amoskeag Health, 145 Hollis Street, Manchester, New Hampshire 03101 and the City of Manchester School District (MSD), 20 Hecker Street, Manchester, New Hampshire 03102. The parties agree to enter into this agreement for the continued provision of behavioral health services for students at the District's Elementary, Middle, and High Schools, and to initiate school-based health services at Beech Street Elementary School and Gossler Park Elementary School.

Purpose:
The purpose of this MOU is to establish an agreement between Amoskeag Health and the Manchester School District that coordinates joint processes and procedures for the provision of services that benefit the District's students and their families, including student programs, family support activities, behavioral health services, supervision, and evaluation of behavioral health services for students at the District's Elementary, Middle, and High Schools, and school-based health services at Beech Street Elementary School and Gossler Park Elementary School.

Services/Duties of Each Partner Organization:
This section describes the responsibilities and agreements of each party.

Amoskeag Health agrees to:

- *Provide behavioral health clinicians (BHCs), community health workers (CHWs), and health providers in accordance with funding availability, demonstrated need, workforce availability, and other local, state, and federal regulations. This may include requirements regarding professional licensure, physical space allowing for confidential service provisions, and location credentialing.*
- *Purchase necessary materials/supplies for its staff to carry out their duties;*
- *Employ managers to supervise the BHCs, CHWs, and health providers and serve as a point of contact for day-to-day communication.*
- *Provide student counseling support services, family support services, and school-based health services only with individualized consent of children's parents/legal guardians;*
- *Support staff in training and professional development opportunities in areas related to programming and students' needs;*
- *Provide access to assessment and other available data for service evaluation in accordance with HIPAA and FERPA;*
- *Support collaborative relationships among school staff, Amoskeag Health staff, and students and their families;*
- *Support positive and welcoming school environments through staff engagement in school activities such as open houses, IEP meetings, and/or parent conferences, and programs such as Leader in Me, Multi-Tiered Systems of Support for Behavior and Wellbeing (MTSS-B), and/or Community Schools Framework.*

Manchester School District:

- *Identify district and school point of contact for grant activities to facilitate successful integration of BHCs into the school and to address any concerns.*

- *Share information related to Amoskeag Health's school-based services to students, staff, and families in order to facilitate referrals;*
- *Support staff in training and professional development opportunities in areas related to programming and students' needs;*
- *Provide private space for BHCs to provide confidential counseling to students*
- *Provide private space for health providers to provide care for students*
- *Provide space for CHWs to be available to families and access to a private space (e.g. conference room) as requested by families*
- *Support collaborative relationships among school staff, Amoskeag Health staff, and students and their families;*
- *Provide access to assessment and other available data for service evaluation in accordance with confidentiality practices under HIPAA and FERPA*

Required Insurance Coverage:

1. Amoskeag Health hereby agrees to protect, defend, indemnify, and hold the MSD, its students, employees, volunteers, agents, officers, and servants free and harmless from any and all losses, claims, liens, demands, and causes of action of every kind and character, including but not limited to, the amounts of judgments, penalties, interests, court costs, legal fees, and all other expenses including claims, liens, debts, personal injuries, death, or damages to property, and without limit by enumeration, all other claims or demands of every character occurring in any way arising directly out of the acts or omissions of Amoskeag Health.
2. Similarly, the MSD agrees to protect, defend, indemnify, and hold Amoskeag Health and its employees, volunteers, agents, officers, and servants free and harmless from any and all losses, claims, liens, demands, and causes of action of every kind and character, including but not limited to, the amounts of judgments, penalties, interests, court costs, legal fees, and all other expenses including claims, liens, debts, personal injuries, death, or damages to property, and without limit by enumeration, all other claims or demands of every character occurring in any way arising directly out of the acts or omissions of MSD.
3. For any claims or suits directly causes by an act or omission of Amoskeag Health, Amoskeag Health agrees to investigate, handle, respond to, provide defense for and defend any such claims, demands, or suits at their sole expense. Amoskeag Health also agrees to bear all other costs and expenses related thereto, even if the claim or claims alleged are groundless, false, or fraudulent.
4. Amoskeag Health agrees to maintain in full force and effect:
    a. Worker's Compensation Insurance per the New Hampshire revised statutes annotated.
    b. Comprehensive General Liability Insurance and/or Professional Liability and Automobile and Trick Liability coverage minimum limits of $1,000,000 per occurrence combined single limit and shall contain minimum limits of $2,000,000 per aggregate.
    c. Comprehensive General Liability coverage and Automobile and Trick Liability coverage may be met with a combination of coverage including excess and umbrella liability coverage.
    d. Any and all deductibles on the above insurance policies shall be assumed by and be for the account of and at the sole risk of Amoskeag Health.
    e. Amoskeag Health agrees to furnish certificates of the above-mentioned insurance to MSD upon execution of this Agreement and, with respect to the renewals of the current insurance policies, at least thirty (30) in advance of each renewal date. Such certificates shall, with respect to comprehensive general liability insurance, name MSD and the City of Manchester as "Additional Insureds" while contractor is performing duties under this Agreement with MSD.

f. The purchase of insurance required or the furnishing of the aforesaid certificate shall not be a satisfaction of Amoskeag Health's liability hereunder or in any way modify Amoskeag Health's indemnification responsibilities to MSD.

Data Confidentiality/HIPAA/FERPA:
MSD's Policy governing student data and privacy is the Board of School Committee ("BOSC") Policy: Students 151. This policy outlines the District's obligations under the Federal Educational Rights and Privacy Act ("FERPA"), as well as R.S.A. 91-A:5, III (Exemptions, Pupil Records) and RSA 189-1-e (Directory Information). A copy of this policy is available online at <http://bosc.mansd.org/policies> under "Students" and at number 151.

1. Under this Agreement, Amoskeag Health is partnering with MSD to provide services to students and therefore both organizations may have access to otherwise protected student information due to its legitimate educational interest in the information and because the information is necessary for each organization to perform their responsibilities and duties as they pertain to MSD students. Amoskeag Health certifies that it cannot provide its services to students without access to student data. Parties to this Agreement understand that MSD will maintain a record of any agency that has access to student records. Amoskeag Health agrees that it will not make any further disclosures of any student data including, but not limited to, any data that Amoskeag Health accesses during provision of services that is governed by Students 151. This disclosure agreement permits Amoskeag Health to access MSD data on students for the purpose of providing the contracted services; release student health information to MSD for the purposes of triage, treatment and disposition, but it prohibits any further disclosure by Amoskeag Health to any other parties. Amoskeag Health will take precautions to ensure the security of any confidential student data in their possession, and will destroy said data upon expiration of this agreement.

2. Amoskeag Health is responsible for providing MSD with a list of employees or members who will need access to student data, as well as notifying MSD if anyone with access to student data leaves employment with their organization, so that their access may be immediately terminated. Amoskeag Health is responsible for maintaining the confidentiality and security of all student data (including maintaining secure files that are password protected), and must notify MSD immediately upon any breach of security.

3. All parties to this agreement hereby certify that they have reviewed BOSC Policy Students 151, and will be responsible for compliance with this policy by all members in their organization, in maintaining and preserving the confidentiality of student data.

4. The Parties shall not disclose any patient/client or protected health information to any third party, except where permitted or required by law or where the client or authorized legal representative expressly approves such disclosure.

5. HIPAA and Hitech Compliance. The Parties shall each comply with all privacy, security and breach notification requirements of HIPAA and Hitech, and shall be responsible for its own costs incurred in connection with achieving and maintaining such compliance of their own information.

Term of Agreement: This agreement is in effect until June 30, 2023, with an option to renew for an additional year until June 30, 2024 under the same terms outlined herein.

Modification and Termination of Agreement: The MOU may be modified or amended by mutual agreement by the issuance of a written amendment, signed and dated by both parties. Any party of the MOU may terminate their participation in this MOU by giving written notice of intent to terminate at least 90 days in advance.

Relationship of Parties: During the term of this Agreement, Amoskeag Health and MSD shall remain separate entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create any relationship between the Parties other than that of separate entities. Except as otherwise provided, neither of the Parties shall be construed to be the agent, partner, co-venturer, employee or representative of the other Party.

Third Party Beneficiaries: This Agreement was created by the Parties solely for their benefit and is not intended to confer upon any person or entity other than the Parties any rights or remedies hereunder.

Assignment: The rights, obligations, and responsibilities established herein shall not be assigned or transferred by either Party without the express written consent of the other Party.

Entire Agreement: This Agreement represents the complete understanding of the Parties with regard to the subject matter. This Agreement supersedes any other agreements or understandings between the Parties, whether oral or written, relating to the subject matter of this Agreement. No such other agreements or understandings may be enforced by either Party nor may they be used for interpretation purposes in any dispute involving this Agreement.

Dispute Resolution: The Parties shall first attempt to resolve any dispute arising under this Agreement by informal discussion between the Parties. Any dispute that has failed to be resolved by informal discussions between the Parties within a reasonable period of time after the commencement of such discussion (not to exceed thirty days) may be resolved through any and all means available.

SIGNATURES:

The terms and conditions of this Agreement are agreed to by the parties upon signature below.

By: _____
Kris McCracken
President and Chief Executive Officer
Amoskeag Health

Date: 01/13/2023

By: _____
Dr. Jennifer Gillis
Superintendent
City of Manchester School District

Date: 1/17/23

Memorandum of Agreement

Student Mentoring and Counseling Support Services

City of Manchester School District
And
Amoskeag Health

This Agreement is made and entered into as of the 1st day of July 2023 by and between Amoskeag Health, 145 Hollis Street, Manchester, New Hampshire 03101, and City of Manchester School District (MSD), 20 Hecker Street, Manchester, New Hampshire 03102. The parties agree to enter into this agreement for the provision of mentoring and counseling support services for students at Beech Street Elementary School.

Purpose of Agreement: The MSD desires to enter into this agreement with Amoskeag Health to provide expansion of existing services to students and their families at Beech Street Elementary School who may need mentoring or counseling supports via social workers and mental health counselors, herein referred to as Behavioral Health Counselors (BHCs). The BHCs, as an extension of the school's social support team, work with students who are not currently receiving special education services through the MSD. The MSD agrees to fund 0.75% of the salary and benefit costs for 1.0 FTE BHC in the school up to the maximum for the 2023-2024 school year as outlined under Reimbursement, #2. Additional funding to cover the remaining 0.25 of the position is funded through Medicaid reimbursement. While several local organizations collaborate to provide a full spectrum of health services in the MSD, Amoskeag Health, the City's Federally Qualified Health Center, is the only entity in the community who is eligible for 100% Medicaid reimbursement for primary health care services for families and provides health care services for all families regardless of their ability to pay and/or current patient status.

Scope of Services: Amoskeag Health shall complete the Scope of Services and tasks identified in the "Responsibilities" section of this Agreement.

Responsibilities:

Manchester School District will:

1. MSD will provide designated office space for each Behavioral Health Counselor.
2. Identify district and school points of contact for grant activities to facilitate successful integration of BHCs into the school and to address any concerns.

Amoskeag Health/Provider will:

- Participate on school-based teams.
- Facilitate school-based psycho-education groups to promote social, emotional, and mental health.
- Provide consultation, mental health education, and prevention information to school personnel.
- Participate in professional development and training opportunities that support evidence-based practices and the MTSS-B model at Manchester School District.
- Provide appropriate feedback to assist school staff in the implementation of behavior plans and MTSS.

- Participate in school programming and meetings with staff, students, and family to monitor and support successes and challenges.
- Serve as a liaison between the Manchester School District and Amoskeag Health to facilitate communication and referrals.
- Exercise clinical/ethical judgment regarding sharing information with school personnel in accordance with state and federal law.
- Complete a fingerprint supported background check in compliance with RSA 189:13-a, or alternatively, require each staff person to complete the background check process through the MSD Human Resources department at the Provider's expense.
- Participate in parent engagement activities such as parent education meetings. Staff have worked with school staff to provide a parent education activity around the social/emotional curriculum.
- Follow the Code of Conduct in the MSD Employee Handbook. MSD may request any Amoskeag staff member to leave the school premises immediately for any violation of the reasonable rules of the schools. The Provider will be notified immediately (within 24 hours) of any such violation by one of its staff.

Reimbursement:

1. MSD agrees to pay Amoskeag Health on a monthly basis via invoices for service delivery upon execution of the Agreement.
2. In no circumstances shall the requested reimbursement amount exceed $70,313.00 for services provided under this agreement.

Required Insurance Coverage:

1. Amoskeag Health hereby agrees to protect, defend, indemnify, and hold the MSD, its students, employees, volunteers, agents, officers, and servants free and harmless from any and all losses, claims, liens, demands, and causes of action of every kind and character, including but not limited to, the amounts of judgments, penalties, interests, court costs, legal fees, and all other expenses including claims, liens, debts, personal injuries, death, or damages to property, and without limit by enumeration, all other claims or demands of every character occurring in any way arising directly out of the acts or omissions of Amoskeag Health.
2. Similarly, the MSD agrees to protect, defend, indemnify, and hold Amoskeag Health and its employees, volunteers, agents, officers, and servants free and harmless from any and all losses, claims, liens, demands, and causes of action of every kind and character, including but not limited to, the amounts of judgments, penalties, interests, court costs, legal fees, and all other expenses including claims, liens, debts, personal injuries, death, or damages to property, and without limit by enumeration, all other claims or demands of every character occurring in any way arising directly out of the acts or omissions of MSD.
3. For any claims or suits directly caused by an act or omission of Amoskeag Health, Amoskeag Health agrees to investigate, handle, respond to, provide defense for and defend any such claims, demands, or suits at their sole expense. Amoskeag Health also agrees to bear all other costs and expenses related thereto, even if the claim or claims alleged are groundless, false, or fraudulent.
4. Amoskeag Health agrees to maintain in full force and effect:

a. Worker's Compensation Insurance per the New Hampshire revised statutes annotated.

b. Comprehensive General Liability Insurance and/or Professional Liability and Automobile and Trick Liability coverage minimum limits of $1,000,000 per occurrence combined single limit and shall contain minimum limits of $2,000,000 per aggregate.

c. Comprehensive General Liability coverage and Automobile and Trick Liability coverage may be met with a combination of coverage including excess and umbrella liability coverage.

d. Any and all deductibles on the above insurance policies shall be assumed by and be for the account of and at the sole risk of Amoskeag Health.

e. Amoskeag Health agrees to furnish certificates of the above-mentioned insurance to MSD upon execution of this Agreement and, with respect to the renewals of the current insurance policies, at least thirty (30) in advance of each renewal date. Such certificates shall, with respect to comprehensive general liability insurance, name MSD and the City of Manchester as "Additional Insureds" while contractor is performing duties under this Agreement with MSD.

f. The purchase of insurance required or the furnishing of the aforesaid certificate shall not be a satisfaction of Amoskeag Health's liability hereunder or in any way modify Amoskeag Health's indemnification responsibilities to MSD.

Data Confidentiality/HIPAA/FERPA: MSD's Policy governing student data and privacy is the Board of School Committee ("BOSC") Policy: Students 151. This policy outlines the District's obligations under the Federal Educational Rights and Privacy Act ("FERPA"), as well as R.S.A. 91-A:5, III (Exemptions, Pupil Records) and RSA 189-1-e (Directory Information). A copy of this policy is available online at <http://bosc.mansd.org/policies> under "Students" and at number 151.

1. Under this Agreement, Amoskeag Health is partnering with MSD to provide services to students and may therefore have access to otherwise protected student information, due to its legitimate educational interest in the information, and because the information is necessary for the organization to perform their responsibilities and duties as they pertain to MSD students. Amoskeag Health certifies that it cannot provide its services to students without access to student data. Parties to this Agreement understand that MSD will maintain a record of any agency that has access to student records. Amoskeag Health agrees that it will not make any further disclosures of any student data including, but not limited to, any data that Amoskeag Health accesses during provision of services that is governed by Students 151. This disclosure agreement permits Amoskeag Health to access MSD data on students for the purpose of providing the contracted services; but it prohibits any further disclosure by Amoskeag Health to any other parties.

2. Amoskeag Health is responsible for providing MSD with a list of employees or members who will need access to student data, as well as notifying MSD if anyone with access to student data leaves employment with their organization, so that their access may be immediately terminated. This agreement is valid until June 30, 2024, at which point all access will be terminated unless a new Agreement is signed. Amoskeag Health is responsible for maintaining the confidentiality and security of all student data (including maintaining secure files that are password protected) and must notify MSD immediately upon any breach of security.

3. Amoskeag Health further agrees that it will not disclose any medical information including, but not limited to, information regarding COVID19 and health symptoms, that it learns while working with MSD students.

4. All parties to this agreement hereby certify that they have reviewed BOSC Policy Students 151 and will be responsible for compliance with this policy by all members in their organization, in maintaining and preserving the confidentiality of student data.

5. The Parties shall not disclose any patient/client or protected health information to any third party, except where permitted or required by law or where the client or authorized legal representative expressly approves such disclosure.

6. HIPAA and Hitech Compliance. The Parties shall each comply with all privacy, security and breach notification requirements of HIPAA and Hitech, and shall be responsible for its own costs incurred in connection with achieving and maintaining such compliance of their own information.

Term of Agreement: Unless otherwise terminated, this *Agreement shall commence July 1, 2023, and conclude on June 30, 2024*. This Agreement ~~shall be~~ reviewed annually. Amoskeag Health is responsible for indicating to MSD interest and intent to enter into a subsequent Agreement before June 30, 2024.

Amendment: This Agreement may be amended, waived, or discharged only by an instrument in writing signed by the party or parties hereto.

Termination of Agreement:

1. When, in the opinion of MSD and with written notice therewith to Amoskeag Health, any or all work performed as described within the Agreement under "Scope of Services" has not been done as provided in this contract to MSD's satisfaction, and further within fifteen (15) days of said written notice, improvement to the extent of the Agreement has not been shown, it shall be deemed a material breach of contract and shall operate as an immediate termination thereof.

2. Notwithstanding anything in this Agreement to the contrary, any of the parties may terminate this agreement without cause upon thirty (30) days written notice to the other parties.

3. The MSD reserves the right to cancel this contract if funds are not appropriated for the continuance of the grant funding.

Relationship of Parties: During the term of this Agreement, Amoskeag Health and MSD shall remain separate entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create any relationship between the Parties other than that of separate entities. Except as otherwise provided, neither of the Parties shall be construed to be the agent, partner, co-venturer, employee, or representative of the other Party.

Third Party Beneficiaries: This Agreement was created by the Parties solely for their benefit and is not intended to confer upon any person or entity other than the Parties any rights or remedies hereunder.

Assignment: The rights, obligations, and responsibilities established herein shall not be assigned or transferred by either Party without the express written consent of the other Party.

Entire Agreement: This Agreement represents the complete understanding of the Parties with regard to the subject matter. This Agreement supersedes any other agreements or understandings between the Parties, whether oral or written, relating to the subject matter of

this Agreement. No such other agreements or understandings may be enforced by either Party nor may they be used for interpretation purposes in any dispute involving this Agreement.

Dispute Resolution: The Parties shall first attempt to resolve any dispute arising under this Agreement by informal discussion between the Parties. Any dispute that has failed to be resolved by informal discussions between the Parties within a reasonable period of time after the commencement of such discussion (not to exceed thirty days) may be resolved through any and all means available.

SIGNATURES:
The terms and conditions of this Agreement are agreed to by the parties upon signature below.

By _____
Kris McCracken
President and Chief Executive Officer
Amoskeag Health

Date: 07/27/2023

By _____
Jennifer Gillis, Ph.D.
Superintendent
City of Manchester School District

Date: 7/25/23

Students 151 STUDENT RECORDS AND ACCESS

STUDENT RECORDS AND ACCESS

It is the policy of the Manchester Board of School Committee that all school district personnel will follow District regulations/procedures as they pertain to the maintenance of student records and comply with the provisions of the Family Educational Rights Privacy Act (FERPA) and its corresponding regulations.

Educational Record. For the purposes of this policy and in accordance with FERPA, the term "educational record" is defined as all records, files, documents and other material containing information directly related to a student; and maintained by the school district; or by such other agents as may be acting for the school district. Such records include, but are not limited to, handwritten documents, videotapes, audiotapes, electronic or computer files, films, prints, microfilm and/or microfiche.

Eligible Student(s). For the purposes of this policy and in accordance with FERPA, the term "eligible student(s)" is defined as a student who is eighteen (18) years-old and currently attending an institution within the District.

Directory Information. For the purposes of this policy and in accordance with FERPA and New Hampshire RSA 189:1-e, the term "directory information" means:

1. Students' name, address, telephone number, date and place of birth, and dates of enrollment;
2. Parents'/guardians' name and address;
3. Students' grade level, enrollment status and dates of attendance;
4. Students' photograph;
5. Students' participation in recognized school activities and sports;
6. Weight and height of members of athletic teams; and

7. Students' diplomas, certificates, awards, and honors received.

Personally Identifiable Information. For the purposes of this section and in accordance with the Code of Federal Regulations (CFR),"personally identifiable information" is defined as data or information which makes the subject of a record known, including a student's name; the student's or student's family's address; the name of the student's parent or other family members; a personal identifier such as a student's Social Security number; the student's date of birth, place of birth, or mother's maiden name; or other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with a reasonable certainty or information requested by a person who the District reasonably believes knows the identity of the student to whom the education record relates.

Disclosure of Student Records and Student Information.

The District may release or disclose educational records of students under the following circumstances:

1. Directory Information. The Information is categorized as Directory Information and does not include any Personally Identifiable Information. The District may only release this information if it provides parents notice of the District's FERPA policy within the first three weeks of school, and provides parents an opportunity to opt-out of this provision.

2. Military Recruiter. Military recruiters are allowed access a high school student's name, address, and telephone number(s) unless the parents of the student or an eligible student request that such information not be released without prior written consent. Further information about military recruiters' access to student information, review the policy Students 158 Recruiters Access to Students.

3. Written Consent. It obtains the written consent of the student's parents/eligible students that specifies the records to be released, the reasons for such release and who will be receiving the released records, and contains a copy of the records to be released which may contain personally identifiable information; or

4. FERPA Exceptions. A specific exception under FERPA or New Hampshire law allows the school to release the educational records, including personally identifiable information, without written consent. This provision applies to the following circumstances:

a. School Officials with a Legitimate Educational Interest. School officials with a legitimate educational interest may access student records, "Legitimate education interest" refers to school official or employees who need to know information in a student's education record in order to perform the employee's employment responsibilities and duties.

b. Other schools into which a student is transferring or enrolling.

c. Officials for audit or evaluation purposes.

d. Appropriate parties in connection with financial aid.

e. Organizations conducting certain studies for, or on behalf of the school district. Student records or student information will only be provided pursuant to this paragraph if the study is for the purpose of: developing, validating or administering predictive tests; administering student aid programs; or improving instruction.

f. Accrediting organizations.

g. Judicial orders or lawfully issued subpoenas.

h. Health and safety emergencies.

Annual Notification/Rights of Parents and Eligible Students. Within the first three (3) weeks of each school year, the District shall publish notice to parents and eligible students of their rights under State and Federal law and the policy Students 151 Student Records and Access. The District shall send home with each student a notice listing these rights. The notice shall include:

1. The rights of parents or eligible students to inspect and review the student's education records;

2. The rights of parents or eligible students to refuse to provide consent to the release or disclosure of education records with personally identifiable information;

3. The intent of the District to limit the disclosure of information in a student's record unless permitted by law, including the definitions of school official and legitimate educational interest;

4. The right of a student's parents or an eligible student to seek to correct parts of the student's educational records.

5. The right of any person to file a complaint with the United States Department of Education if the District violates FERPA; and

6. The procedures that a student's parents or an eligible student should follow to obtain copies of this policy, to inspect their own records, or to request to amend their records.

Procedure to Inspect Education Records. Parents or eligible students may inspect and review educational records. Parents/eligible students should submit to the school principal a request that identifies as precisely as possible the record or records that they wish to inspect. The principal shall contact the parents or the eligible student to discuss how access is best arranged for their inspection or review of the records (copies, records brought to a single site, etc.). Copies may be provided if the parent or eligible student cannot personally inspect the records due to a hardship such as working hours, health, or distance between record location sites.

The principal shall notify the parent or eligible student of the time and place where the records may be inspected. This procedure must be completed within 14 days or earlier after the principal's receipt of the request for access.

When records contain information about students other than a parent's child or the eligible student, the parent or eligible student may not inspect and review the records of the other students. If such records do contain the names of other students, the principal shall seek consultation with the Superintendent and/or District's attorney to determine how best to proceed.

Procedures To Seek To Correction of Education Records. Parents of students or eligible students have a right to seek to change any part of the student's records which they believe is inaccurate, misleading or in violation of student rights. Parents/eligible students seeking to exercise this right may do so in one of two ways.

1. Request for Review. When a parent or eligible student finds an item in the student's education records that they believe is inaccurate, misleading or in violation of student rights, they should submit a request asking the building principal to correct it. This request may be submitted in writing, or it may be communicated to any current school official who will then

communicate it to the principal. If a parent/eligible student submits their request through the latter, the principal will record the date that the request was submitted. If the records are incorrect because of clear error and it is a simple matter to make the change, the principal should make the correction. If the records are changed to the parent's/eligible student's satisfaction, both parties shall sign a document/form stating the date the records were changed and that the parent/eligible student is satisfied with the correction.

If the principal believes that the record should not be changed, they may deny the request for the change and provide a copy of the questioned records to the requester at no cost. The principal shall inform the requestor of their right to appeal to the Superintendent-by submitting a formal request for the change. Upon receipt, the principal shall forward this written request to the Superintendent for their consideration and inform the requestor of the date the written request was sent to the Superintendent.

The Superintendent shall review and respond to the request within ten business days after receiving notification of the request. The Superintendent may schedule a meeting with the requester, if necessary, within the 10 business days. If the Superintendent determines the records should be amended, they will make the change, notify the parents/eligible student in writing that the change has been made, and invite the parent/eligible student to inspect and review the amended records. Both parties shall sign a document/form stating the date the records were changed and that the parent/eligible student is satisfied with the corrections.

If the Superintendent determines the records will not be amended, they will notify the parents/eligible student in writing of their decision and inform the parents/eligible student of their right to an appeal hearing before the Board of School Committee.

2. Hearing. Alternatively, at any time before, during, or after a parent or eligible student exercises their right to have the contested record reviewed, they may submit a written request for a hearing before the Board of School Committee to the Superintendent.-The Superintendent shall inform the Board of School Committee of the request for a hearing and will work with the Board of School Committee to schedule a hearing within 45 days of receipt of the request. The Superintendent will then inform the parents in writing of the hearing's date, time, and place.

The hearing shall be held in non-public session consistent with the provisions of RSA 91-A:3 unless the parent/eligible student requests that the hearing be held in public session. The Board of School Committee shall give the parent/eligible student a full and fair opportunity to

present evidence. Parents/eligible students may bring an advocate of their choice to the hearing who may be an attorney.

The Board of School Committee shall issue its final decision in writing within 30 days of the hearing and will include a summary of the evidence and the reasons for its decision. The Board may grant the request and direct the Superintendent to amend the record, or may deny the request, which decision shall be final. This decision will be sent to the parents/eligible student thereof via certified mail, return receipt requested.

The Superintendent shall then contact the parents/eligible student for a meeting. If the record was amended to the parent or eligible student's satisfaction, both parties shall sign a document finalizing the amendments. If the changes were not made to the parent or eligible student's satisfaction, they may submit a statement disagreeing with the decision to be placed in the educational record. This statement must be maintained as long as the record is maintained and must be disclosed whenever the relevant educational record is disclosed.

Maintenance of Student Records and Data. The principal of each building is responsible for the maintenance, access and destruction of all student records. All entries into student records must be dated and signed by the person accessing such records. The principal will ensure that all records are maintained in accordance with application retention schedules as may be established by law.

Disclosures Made from Education Records. The District shall maintain an accurate record of all individuals, agencies, or organizations which have requested and/or obtained access to a student's education records, with some exceptions listed below. This record shall name the individual or agency seeking access, the basis for their access (including a full explanation of any FERPA exception), and the date(s) of their access. In the event of a health and safety emergency, the record must include the articulable and significant threat to the health and safety of a student or other individuals that formed the basis for the disclosure; and the parties to whom the agency or institution disclosed the information.

This record is kept with, but is not a part of, each student's cumulative record and may be made available to parents/ eligible students, or federal, state or local officials for the purpose of auditing or enforcing federally supported educational programs.

The District shall maintain this record as long as it maintains the student's education record.

The records do not include requests for access, or which have been granted to parent(s) of the student or to an eligible student or disclosures made upon their written consent, or requests for access or access granted to officials of the District who have a legitimate educational interest in the student.

Legal References:

RSA 91-A:5, III, Exemptions, Pupil Records

RSA 189:1-e, Directory Information

20 U.S.C. §1232g. Family Educational Rights and Privacy Act

34 C.F.R. Part 99, Family Educational Rights and Privacy Act Regulations

History:

Revised from 9/27/10

First Reading Coordination: 4/9/13

Second Reading and Adoption by BOSC: 4/29/13

First Reading (Policy Committee): August 10, 2021

Second Reading & BOSC Adoption: August 23, 2021

AMOSKEAG HEALTH

Patients Name: _____

Patients Date of Birth: _____

CONSENT TO TREAT

By signing below, I, (or my authorized representative on my behalf, or on behalf of my child as lawful parent/guardian) agree and authorize: Amoskeag Health and all of its included sites and departments to render to me any health services and treatment that are deemed necessary, in accordance with Amoskeag Health's policies and procedures.

As physical and behavioral health problems often go together, we at Amoskeag Health believe the best care is given when health care providers work together. Amoskeag Health patients may be referred to other Amoskeag Health providers, including Behavioral Health Specialists and Drug and Alcohol Treatment Providers.

The staff of this organization will depend on statements made by the patient, the patient's medical history and other information to evaluate his/her condition and decide on the best treatment. The evaluation of children and adolescents often requires the involvement of parents and/or other family members.

I understand that in New Hampshire, if I am 12 years old or older, I can consent to Drug and/or Alcohol Abuse Treatment without the consent of a parent or guardian, and if I am 14 years old or older, I can consent to services related to Contraception and Sexually Transmitted Infections without the consent of a parent or guardian.

I further authorize my Treatment Provider/Amoskeag Health Staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness(es) or injuries.

I understand that it is the responsibility of my individual treating healthcare providers to explain the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated benefits associated with these options, as well as alternative courses of treatment. Any questions about benefits, risks, available options or the limits of confidentiality should be directed to the treatment staff.

I understand in giving my general consent to treatment that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Consent to Share Medical Records/Health Information

I understand that if, at any time during the course of my treatment, a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

I understand that this consent in its entirety will remain in effect as long as I continue to receive health care services at Amoskeag Health.

_____ _____

Signature of the Patient **Date**

_____ _____

Signature of Parent/Guardian **Signature of Witness/Interpreter**

AMOSKEAG HEALTH

Patient Information Form

Please Print Clearly

Patient Name:

_____ Date of Birth: _____
Month / Day / Year

Preferred Name (if Different): _____ Sex assigned at Birth: __Male __ Female

What are your Pronouns: __He/Him/His __She/Her/Hers __They/Them/Theirs __Other _____

Marital Status: __ Single __ Married __ Divorced __ Separated __ Widowed __ Significant Other/Partner

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____
Check One → __ Cell __ Home __ Work **Check One → __ Cell __ Home __ Work**

Email Address: _____

I Authorize Amoskeag Health to communicate: By Email: __ Yes __ No By Text: __ Yes __ No

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

<u>If the patient is under 18 years of age, please complete this section.</u>

Parent/Mother Name: _____ Date of Birth: _____
Month / Day / Year

Parent/Father Name: _____ Date of Birth: _____
Month / Day / Year

Legal Guardian Name: _____ Date of Birth: _____
Month / Day / Year

Do you see someone for mental/behavioral health, psychiatry, counseling or substance use disorders? If yes, please enter their name and agency here: _____

Please provide your Insurance card(s) so we can make a copy.

Name of policy holder: _____ Date of Birth: _____
Month / Day / Year

Relationship to patient: _____

Whom does your insurance company list as your Primary Care Provider? _____

Secondary Insurance/Name of policy holder: _____ Date of Birth: _____

Month / Day / Year

Relationship to patient: _____

I do not have health insurance. Please ask about our Financial Assistance Programs.

AMOSKEAG HEALTH

Patients Name: _____

Patients Date of Birth: _____

I have received a copy of **Patient Contract for Care and Referral Payment Acknowledgement**. By signing below, I acknowledge that I have read and understand these documents. Further, I understand that I am financially responsible for the payment of nominal fees and deductibles at the time of service; payment for services rendered outside of Amoskeag Health.
By signing below, I state that the information I have provided is true, and I am authorizing Amoskeag Health to verify that information, and release it to referring mutual providers of care. Any information provided that is discovered to be false now, or in the future, could be considered fraud for which I could be held liable and denied services permanently. I also agree to allow Amoskeag Health to share demographic and income data with State, Federal and Private grantors as necessary.
I, the undersigned, certify that I have insurance coverage and assign all insurance benefits payable to Amoskeag Health otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the named health care entity to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

I have received a copy of **Electronic Transaction of Health Care Business and Affiliate Access Agreement**. By signing below, I am confirming that I understand and agree to have Amoskeag Health conduct all of my health care transactions electronically or to view electronically the minimum necessary pertinent health information in my record in order to provide care. This may be for the purpose of a referral to Dartmouth Hitchcock for a specialist or procedure, coordination of care with the Mental Health Ctr. of Greater Manchester, to Elliot Hospital for in-patient care, emergency department care. In addition, outpatient referrals to the Manchester Health Department to coordinate care for communicable diseases (including TB), lead and immunizations or to provide the school nurses through Manchester School Department access to immunizations, physicals or medication information.

I have received a copy of the **Notice of Privacy Practices and Patient Bill of Rights**. By signing below, I acknowledge receipt and understanding of these documents.

We have Free Trained Interpreters to help you. This is a FREE service that we encourage you to use, and it will not in any way negatively affect the care you receive at our facility. Do you have someone else you prefer to interpret for you?

_____ _____

Name Relationship

_____ _____

Name Relationship

I have received a copy of the **Language Access Form**. By signing below, I give Amoskeag Health staff permission to conduct all verbal conversations (by phone or in person) through the individuals I have listed above, through their phone number or mine. I am aware that any and all confidential information will be discussed freely through the interpreter I have chosen to use. As a result, I am giving Amoskeag Health permission to share Protected Health Information with this person(s). This may include topics such as billing, insurance, registration information, appointment setting, and other health care transactions, as well as interpreting to the provider or other clinical staff information I may consider sensitive, such as lab results, referrals, diagnosis, HIV status, substance issues, mental health problems, or any other problem I need help with at Amoskeag Health. My family member is not bound to a confidentiality agreement with Amoskeag Health, and it is therefore my decision to risk sharing this information through my family member(s), as Amoskeag Health cannot be held accountable for their confidentiality, not their accuracy in the interpretation of the

information. If at any time a staff member feels my family member is doing a sub-standard job or has other concerns, we may choose to use a professional interpreter or staff member to protect my best interests.

_____ _____

Signature of Insured/Responsible Party Date
Patient/Parent or Legal Guardian

AMOSKEAG HEALTH

Patients Name: _____
Patients Date of Birth: _____

Amoskeag Health receives state and federal funding to support our services. We are required to collect and report on this information. These questions are asked to all patients regardless of age, gender, race or marital status. Your assistance in completing this information will help us to apply for future grant funding. **All information is confidential.**

Ethnicity: Are you Hispanic , Latino/a, or Spanish origin?
(One or more categories may be selected)
☐ No, not of Hispanic, Latino/a, or spanish origin
☐ Yes, Mexican, Mexican American , Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino or Spanish Origin

Is English your Primary Language?
(5 years or older) ☐ Yes ☐ No
If no, what is your primary language? _____
Do you need an Interpreter? ☐ Yes ☐ No
Are you hearing impaired? ☐ Yes ☐ No
Do you need a sign language interpreter? ☐ Yes ☐ No

What is your race?
(one or more categories may be selected)
☐ White ☐ Black/African
☐ American Indian or Alaska Native
☐ Asian Indian ☐ Other Asian
☐ Filipino ☐ Korean
☐ Vietnamese ☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan ☐ other Pacific Islander

Are You... (Check all that apply)
☐ Full Time Student ☐ Part Time Student
☐ US Veteran ☐ Migrant Worker
☐ Seasonal Worker

Highest Level of Education Completed:
☐ Pre-school ☐ Elementary
☐ Middle School ☐ High School Graduate
☐ GED ☐ High School (did not graduate)
☐ Technical School ☐ Some College
☐ Associate Degree ☐ Bachelor Degree
☐ Graduate/Masters Degree ☐ Doctorate Degree

Citizenship Status:
☐ US Citizen by birth
☐ US Citizen First Generation
☐ US Citizen by Naturalization
☐ Immigrant ☐ Refugee
☐ Student Visa ☐ Work Permit
☐ Permanent Resident/Alien ☐ Other: _____

Sexual Orientation:
☐ Bisexual
☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Something else
_____
☐ Don't know
☐ Choose not to disclose

Gender Identity:
☐ Female ☐ Male ☐ Nonbinary
☐ Transgender male/female-to-male (FTM)
☐ Transgender female/male-female (MTF)
☐ Another gender category (please specify):
☐ Choose not to disclose

Living Arrangements
☐ Rent
☐ Street (car, tents)
☐ Own a home
☐ Shelter
☐ Public housing
☐ Living with Relatives/friends
☐ Transitional housing (New Life Home, Halfway House, etc)

Over $50,000
☐ Less than $10,000
☐ $10,000 - 14,999
☐ $15,000 - 19,999
☐ $20,000 - 29,999
☐ $30,000 - 49,999
☐ $30,000 - 49,999
☐ Over $50,000

Referral Source: *How did you hear about us?*
☐Hippo Press ☐Union Leader
☐Radio station: _____
☐Facebook ☐Website
☐Friend/Family member
☐Elliot Hospital
☐Catholic Medical Center
☐Dartmouth Hitchcock
☐Insurance Company

☐ Other (Motel, Rooming/Boarding house, etc)

☐Other:_____

Female Head of Household? ☐ Yes ☐ No
How many Adults live in the house? _____
How many Children live in the house? _____

Transportation Status
☐Own Car ☐Bus ☐Share Car
☐Walk ☐Use Wheelchair Van
☐None- Need help

AMOSKEAG HEALTH

Patients Name: _____
Patients Date of Birth: _____

Authorization for Designation of Personal Representative

By signing below, I authorize Amoskeag Health to discuss and disclose my personal health information to the person(s) named below for the purpose of asssisting with, or facilitating the coordination of appointments for me or to assist in coordinating payment for health care services provided to me, per the **Authorized Representative policy** provided to me.

Authorized Reprentative:
Name:_____**Phone Number:** (____)_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Relationship to Patient:_____

Limitations on Disclosure:_____

Authorized Reprentative:
Name:_____**Phone Number:** (____)_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Relationship to Patient:_____

Limitations on Disclosure:_____

By signing below, I authorize the person(s) named below to **pick up prescriptions or medication** at Amoskeag Health as disclosed in the **Prescription Pick-up Authorization policy** provided to me.

Authorized Name:_____

Authorized Name:_____

By signing below, I authorize the person(s) named below to **pick up Medical Records** at Amoskeag Health when I am not present. I certify that the individual(s) name below is 18 years of age or older. I understand that this privilege will remain in effect as long as I am a patient at Amoskeag Health. I may revoke this privilege at any time by providing Amoskeag Health with a letter indicating my wishes.

If you agree to grant this privilege, Amoskeag Health will be held harmless for any unauthorized use of your medical records once they leave the premises. If your medical record(s) is lost, it will not be the responsibility of Amoskeag Health to provide you with a replacement.

Authorized Name:_____

Authorized Name:_____

Signature of Insured/Responsible Party
Patient/Parent or Legal Guardian

Date

AMOSKEAG HEALTH

Patients Name: _____

Patients Date of Birth: _____

Authorization for Designation of Parental Consent

By signing below, I consent to allow the providers at Amoskeag Health to provide care when I am not present, to my minor child who is under the age of 18 years for the following care, treatment and examination.

Please check below the type of care you approve:

- ☐ Physical Examinations (School Physicals, Well Child Checks, Camp Physicals, Sports Physicals, etc.)
- ☐ Female Examinations (Pap Smears/ Breast Exams)
- ☐ Immunizations
- ☐ Sick Care (Acute illnesses such as colds, flu, or other problems)
- ☐ Counseling Services
- ☐ Health Education
- ☐ Follow-up care for ongoing conditions (for example: asthma, weight problems, acne, diabetes, and medical problems)

I authorize the following individual(s) to accompany my minor child to appointments at Amoskeag Health. I certify that the individual(s) named below is 18 years of age or older.

Authorized Name:_____

Authorized Name:_____

Signature of Insured/Responsible Party
Patient/Parent or Legal Guardian

Date

By signing below I consent to allow my minor child (age 16-18) to attend appointments without a parent or guardian.

Signature of Insured/Responsible Party
Patient/Parent or Legal Guardian

Date

AMOSKEAG HEALTH

Patients Name: _____

Patients Date of Birth: _____

AGREEMENT

To All Our Patients:

Please be advised that because of our concern for your health and well-being, it is unlikely that we will be able to provide the following medications to you:

OXYCONTIN	XANAX (APRAZOLAM)
OXYCODONE	VALIUM (DIAZEPAM)
HYDROCODONE	ATIVAN (LORAZEPAM)
PERCOCET	KLONOPIN (CLONAZEPAM)
LORTAB	RESTORIL (TEMAZEPAM)
MORPHINE	LIBRIUM (CHLORDIAZEPOXIDE)
TYLENOL #3	TRANXENE (CLORAZEPATE)
SOMA	STIMULANTS FOR ADULTS
AMBIEN	LUNESTA
METHADONE	VICODIN
SUBOXONE	ULTRAM (TRAMADOL)

If you are on any of these medications (or related substances) or feel you need one of the above medications, please understand that your provider may not prescribe these medications for you. These medications all have the potential for long-term complications and we do not want to put our patients at risk for these problems.

PATIENT SIGNATURE: _____ DATE: _____

Staff Representative Signature: _____ DATE: _____

AMOSKEAG HEALTH

Patients Name: _____

Patients Date of Birth: _____

ACKNOWLEGEMENT OF LAWFUL PARENT/GUARDIAN

Patient Name:_____ **Date of Birth:** _____

For Parent or Guardian to complete:

Name of Biological Mother: _____ **Date of Birth:** _____

Name of Biological Father: _____ **Date of Birth:** _____

Name of Legal Guardian: _____ **Date of Birth:** _____

I _____ (Name of Parent/Legal Guardian) residing

at _____ (Parent's Address), State/Country _____,

acknowledge that I am the lawful parent/guardian of _____ (Name of Child)

_____ (DOB of Child) and that there are no court orders or other documents in effect that would prevent me from conferring

the power of consent to another person.

I understand that this consent in its entirety will remain in effect as long as I continue to receive health care services at Amoskeag Health.

_____ _____

Name of the Parent/Guardian **Date**

_____ _____

Signature of Parent/Guardian **Signature of Witness/Interpreter**

AMOSKEAG HEALTH

Patients Name: _____

Patients Date of Birth: _____

Rev. 6/2/2021

INCOME VER

To Applicants: Our program has benefited from contracting with MCRC/CBDO Special Activities. MCRC receives funding provided by the City of Manchester Community Improvement Program, through the U.S. Housing and Urban Development Community Development Block Grant Program. As a partnering agency of the CBDO, we are required to report the income verification statistics from applicants.

This information will not be shared and will remain confidential.

Part 1. Income and Household Data

Please choose the row that represents your family size and circle the family household income** range in the same row.

NUMBER OF PERSONS IN FAMILY	FAMILY INCOME RANGE ↓	FAMILY INCOME RANGE ↓	FAMILY INCOME RANGE ↓	FAMILY INCOME RANGE ↓
1 Person →	$0 – $18,800	$18,801 – $31,300	$31,301 – $50,050	$50,051+
2 Persons →	$0 – $21,450	$21,451– $35,750	$35,751 – $57,200	$57,201+
3 Persons →	$0 – $24,150	$24,151 – $40,200	$40,201 – $64,350	$64,351+
4 Persons →	$0 – $26,800	$26,801 – $44,650	$44,651 – $71,450	$71,451+
5 Persons →	$0 – $31,040	$31,041 – $48,250	$48,251 – $77,200	$77,201+
6 Persons →	$0 – $35,580	$35,581 – $51,800	$51,801 – $82,900	$82,901+
7 Persons →	$0 – $40,120	$40,121– $55,400	$55,401 – $88,600	$88,601+
8 Persons →	$0 – $44,660	$44,661 – $58,950	$58,951 – $94,350	$94,351+

**Note: Family household income includes wages and salaries, interest, net business income, social security, pensions, alimony received, VA benefits and educational benefits received by all family members living in the household. Alimony paid may be deducted.

For example: A family of 3 with a family income of $33,655 would be represented as:

NUMBER OF PERSONS IN FAMILY	FAMILY INCOME RANGE ↓	FAMILY INCOME RANGE ↓	FAMILY INCOME RANGE ↓	FAMILY INCOME RANGE ↓
3 Persons →	$0 – $24,150	$24,151 – $40,200	$40,201 – $64,350	$64,351+

Part 2. Race, Ethnicity and Household Data

Please provide the number of all persons applying to participate in this program next to appropriate race(s) (count all that apply) and ethnicity characterization, and check the household characterization(s) that apply. A number of different categories may apply; *please mark all that apply.*

RACE	ETHNICITY
_____# White	_____# Hispanic or Latino
_____# Black/African American	
_____# Asian	
_____# American Indian/Alaskan Native	
_____# Native Hawaiian/Other Pacific Islander	
_____# American Indian/Alaskan Native & White	
_____# Asian & White	
_____# Black/African American & White	
_____# American Indian/Alaskan Native & Black/African American	
_____# Asian/Pacific Islander	
_____# Other Multi-Racial_____	
HOUSEHOLD	
_____# Elderly (62+ years) _____# Female Head of Household	_____# Disabled

Name:_____

Address: _____

Census Tract / Block: _____

More than 1 Beneficiary in household – please provide names:

1. _____
2. _____
3. _____
4. _____

I declare that all information provided above regarding household income is true and correct. I understand that knowingly providing false or incomplete information is unlawful and can lead to prosecution for fraud.

_____ Signature

_____ Printed Name

_____ Date