

Delaware Health and Social Services

Division of Public Health

Attachment A

Application for Becoming a State Recognized School Health Services Provider for Non-Contracted Entities

Cover Sheet

Name of Applicant Organization and Tax ID#:																			
Applicant Organization Contact: Name: Phone: Email:																			
School Name(s) and locations (addresses):																			
Source of 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																		
<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	_____																		
Program Description: (Please provide a description of the program and services to be provided.)																			



Delaware Health and Social Services

Division of Public Health

Attachment A

Application for Becoming a School Health Services Provider for Non-Contracted Entities

Cover Sheet cont.

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 governing entity approval) <input type="checkbox"/> HIV Testing and Counseling Services (subject to governing entity approval) <input type="checkbox"/> Reproductive Health Services (subject to governing entity approval) <input type="checkbox"/> Other
<u>ASSURANCES:</u>	
Compliance with DE Regulations. I have read and agree to comply with the following Delaware Regulations: 16 Del. R. §4102 and DE Codes in relationship to: 13 Del. C. §708. and CH# 18 Del.C. §§3365 and 3517G	<hr/> <p>Signature</p> <hr/> <p>Title</p> <hr/>

Delaware Health and Social Services

Division of Public Health

Attachment A

Application for Becoming a School Health Services Provider for Non-Contracted Entities

Cover Sheet cont.

	Date
Updating of contact Information: I agree to notify DPH if any of the information provided in this application to become a School Health Services Provider Non-Contracted Entity changes.	_____ Signature _____ Date
Date of Provider Application: Application for becoming a School Health Services Provider Non-Contracted Entity is submitted on _____.	_____ Signature _____ Date

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

Division of Public Health
Fred MacCormack
Director
Adolescent Health and School-Based Health Center
417 Federal Street
Dover, DE 19901

Or via email to: Fred.MacCormack@state.de.us