

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

Cover Sheet

Name of Applicant Organization and Tax ID#: _____

Applicant Organization Contact: _____

Name: _____

Phone: _____

Email: _____

School Name(s) and Location(s)/Adresse(s) of the Center(s):

Source of Health Services Program Funding: (Check all that apply.)

Source	Amount, if known
_____ None	_____
_____ Local/county funds	_____
_____ Other health providers	_____
_____ Other state funds	_____
_____ Private donors/organizations	_____
_____ Federal funds	_____
_____ Other	_____
_____ In-kind	_____





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Cover Sheet *cont.*

Program Description: (Please provide a description of the program and services to be provided.)

Services to Be Provided:

- | | |
|---|---|
| <input type="checkbox"/> Diagnosis and treatment of acute medical conditions | <input type="checkbox"/> Minor laboratory tests |
| <input type="checkbox"/> Identification and referral of chronic conditions | <input type="checkbox"/> Diagnosis and treatment of STDs
<i>(subject to school board or governing entity approval)</i> |
| <input type="checkbox"/> Mental health counseling and referral | <input type="checkbox"/> HIV testing and counseling services
<i>(subject to school board or governing entity approval)</i> |
| <input type="checkbox"/> Prescribing and/or dispensing of non-prescription/prescription medications | <input type="checkbox"/> Reproductive health services
<i>(subject to school board or governing entity approval)</i> |
| <input type="checkbox"/> Health education | <input type="checkbox"/> Other |
| <input type="checkbox"/> Immunizations | |
| <input type="checkbox"/> Nutrition counseling, consultation, and/or education | |



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Cover Sheet *cont.*

Compliance with DE SBHC Regulations:

I have read and agree to comply with the State of Delaware Regulation(s), 18 Del.C. §§3365 & 3571G.

Signature

Date

Title

Updating of Contact Information:

I agree to notify DPH if any of the information provided in this application to become a State-Recognized School Health Services Provider changes.

Signature

Date

Date of Provider Application:

Application for becoming a State-Recognized School Health Services Provider is submitted on

_____ .

Signature

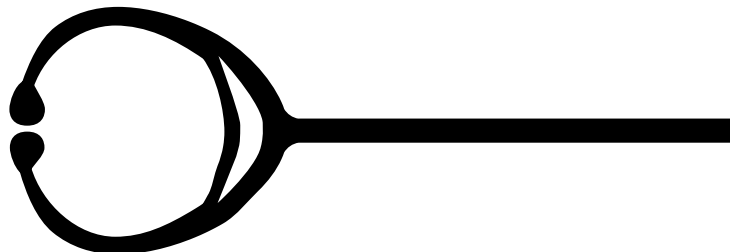
Date

Please complete Attachment A and B.

The completed package may be emailed to DHSS_DPH_SBHC@Delaware.gov.

Or it can be mailed to:

**Division of Public Health
School-Based Health Centers
1351 W. North St., Suite 103
Dover, DE 19904**



For questions, call 302-608-5741.