



**Children's
Volunteer**
Health Network, Inc.

Volunteer Provider Handbook

*Tricia Carlisle-Northcutt**
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Vice President

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Dennis Peters
Treasurer

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Dr. Priscilla Fowler
Courtney Carlisle-Bolton
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Executive Director
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Founding Board Member*



healthy *happy* **kids**
www.cvhnkids.org

P O Box 2142
Santa Rosa Beach, FL 32459
850-622-3200 Fax: 850-622-5434



CHILDREN'S VOLUNTEER HEALTH NETWORK, INC.

Children's Volunteer Health Network, Inc. provides free access to quality medical, dental and mental health services to uninsured and underserved children in the area. CVHN was founded in 2005. Our management team consists of the Board of Directors and officers of CVHN who work closely with the Executive Director. The work is divided among committees as CVHN relies heavily on volunteers.

The Services:

CVHN facilitates the delivery of free, comprehensive direct medical, dental and mental health services to school children who are uninsured or underinsured. We do this by utilizing a network of physicians, dentists and other providers who donate their services at no charge. These providers are supported by the efforts of community volunteers, in-house case management staff and school personnel.

The volunteers and staff are the advocates/liasons coordinating hospital, pharmacy and medical laboratory appointments that may be necessary for a child's treatment.

Medical Services

Allergy/Asthma, Audiology, Dermatology, Ear/Nose/Throat, Family Practice, Internist, Neurology, OB/Gyn, Oncology, Ophthalmology, Orthopedics, Podiatry, Surgery

Ancillary Services

Pharmacy, Lab Work, Diagnostic Imaging

Dental Services

Ongoing referrals to CVHN Dentists, Orthodontic Evaluations & Dental Hygiene

Mental Health Services

Variety of Mental Health Professionals

Insurance Outreach and Advocacy

Helping families obtain affordable health insurance and assisting families to navigate through the health care system

Transportation

Volunteers screened and provide transportation to healthcare appointments.

Our work is never finished. The needs of our community continue to grow. If a specialty is not listed above, please contact our office to discuss the option of including this specialty in our network.

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The Market:

Research shows that 60% of working families are uninsured and over half of these are children. An average of 50% of Okaloosa and Walton Counties students are on free or reduced lunch. This figure continues to increase.

As the county grows and prospers, it only makes good economic sense to invest the energy, money and time necessary to get these children the help they need. Many of these kids fall short of being qualified for Florida Kid Care. Or, they *do* qualify and many times Kid Care covers only a fraction of the cost of the service.

One client, a 16-year-old girl, has a 60% hearing loss and needs hearing aids. She is Florida Kid Care qualified, but only \$250 is allocated for the \$5,000 cost of the hearing aids. This is only one of the many examples that these children and their families encounter.

Since our inception in August 2005, we have helped over 400 children receive much needed health care. We currently have over 90 healthcare providers, including dentists, doctors, and mental healthcare providers in the CVHN network.

CVHN recognizes the need for a coalition of service providers to best utilize the resources available in the community and is actively coordinating a council of community resources to integrate services that are available to our clients.

Financial Consideration:

Our main strategy is the individual ongoing participation of the community. We plan to grow financially through individual donations, corporate benefactors, applying for grants monies and through sponsors. We will continue to grow our network of healthcare professionals. And in 2008, we started a mobile dental clinic program that provides preventive dental care to kids pre-K through 3rd grade in Walton County elementary schools on the free or reduced lunch programs.

Please consider us in your donations and gifting. Our children are our future and they are our hearts.

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CHILDREN'S VOLUNTEER HEALTH NETWORK, INC.

QUICK OVERVIEW OF REFERRAL PROCEDURES

(MEDICAL PROVIDER RESPONSIBILITIES ARE FOUND IN SHADED AREA)

- CHILD PRESENTS WITH MEDICAL PROBLEM EITHER AT SCHOOL OR AT HOME.
 - CHILD IS REFERRED TO CVHN.
 - CVHN VERIFIES INSURANCE STATUS, ELGILIBLTY AND SCREENS APPLICANT.
 - CVHN COMPLETES REFERRAL FORM AND OBTAINS PARENTAL CONSENT.
 - CVHN OBTAINS APPOINTMENT WITH MEDICAL PROVIDER AND FAXES OVER CHILD'S INFORMATION ALONG WITH APPOINTMENT WALK OUT FORM.
 - CVHN PROVIDES TRANSPORTATION IF NECESSARY
- A COPY OF THE CHILD'S REFERRAL FORMS ARE FAXED TO THE MEDICAL PROVIDER BEFORE SCHEDULED APPOINTMENT TIME. AFTER THE APPOINTMENT, THE MECICAL PROVIDER FILLS OUT WALK-OUT FORM. **CVHN MUST BE NOTIFIED OF ANY ADDITIONAL APPOINTMENTS OR REFERRALS, AS THEY ARE RESPONSIBLE FOR FOLLOWING UP WITH THE FAMILY AND COORDINATING ADDITIONAL VISITS.** FOLLOW-UP APPOINTMENTS OR REFERRALS TO ANOTHER SPECIALTY CAN BE INDICATED ON THE REFERRAL FORM. IF IMMEDIATE FOLLOW UP IS NECESSARY (I.E. MEDICATION, FURTHER TESTS, ETC.) PLEASE CALL CVHN AT 850-622-3200. PLEASE FEEL FREE TO CALL CVHN IF YOU HAVE QUESTIONS.
- THE COMPLETED WALK OUT STATEMENT (A DETAILED REPORT LISTING ALL EXPENSES AND COSTS THE PATIENT WOULD HAVE INCURRED) INDICATING "NO CHARGE" ARE THEN FAXED BACK TO CVHN, ALONG WITH ANY COPIES OF BILLING STATEMENTS FROM THE PROVIDER'S OFFICE.
- CVHN REVIEWS THE WALK OUT STATEMENT AND MAKES NOTE OF ANY FOLLOW-UP APPOINTMENTS. IF A REFERRAL TO ANOTHER SPECIALTY IS INDICATED, CVHN WILL MAKE THAT APPOINTMENT. IF ADDITIONAL TREATMENT IS REQUIRED, CVHN WILL ARRANGE THIS AS WELL.
 - CVHN WILL FOLLOW UP WITH THE FAMILY AND ARRANGE FOR ANY ADDITIONAL APPOINTMENTS AND TRANSPORTATION.

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Date _____

Children's Volunteer Health Network, Inc. Referral Form

Last Name of Child _____ First Name _____ M ___ F ___

Age _____ DOB _____ SS# _____ Race _____

Address _____ City _____ St ___ Zip _____

Phone _____ Cell Phone _____

Name of Parents: Mother _____ Primary Language _____

Father _____ Primary Language _____

Name of Guardian _____ Primary Language _____

Mother Place of Work _____ Phone _____

Father Place of Work _____ Phone _____

School _____ School Grade _____

Home Room Teacher's Name _____

Is child in Exceptional Student Education Program? Yes ___ No ___

Current Medical/Dental Problem _____

Significant Medical History _____ Allergies? _____

Does your child need counseling? Yes ___ No ___

Current Medications _____

Chronic Conditions _____

Immunizations up to date? Yes ___ No ___ If No, what is needed? _____ Medicaid? Yes

___ No ___ Kid Care? Yes ___ No ___

Free/Reduced Lunch Program? Yes ___ No ___ Date of last physical _____

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Parent or Guardian Consent/Release

I give my consent for CVHN Doctor to provide evaluation and treatment for my child, _____, and understand that he/she is seeing my child free of charge this *one*

time only. I understand that he/she will not become my child's permanent health care provider and is providing this care on this date only, unless otherwise specified by the doctor. I will arrange for follow-up care for my child through a clinic facility, or through arrangements with another physician at my own expense. I understand that this program does not cover hospitalization.

Parent or Legal Guardian _____ **Parent signs here** Date _____

A Children's Volunteer Health Network, Inc. volunteer has my permission to transport myself and/or my child to the appointment.

Parent or Legal Guardian _____ **Parent signs here** Date _____

I understand that CVHN is a registered non-profit charitable organization dedicated to helping children in need of health care. In giving my consent, I agree to hold harmless Children's Volunteer Health Network, Inc., its agents, administrators, staff and volunteers, and hereby release CVHN from all liability relating to or arising from any activities or services lawfully provided pursuant to this consent.

Parent or Legal Guardian _____ **Parent signs here** Date _____

CVHN Case Worker _____ **CVHN signs here** Date _____

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**AUTHORIZATION FOR THE RELEASE
OF HEALTH-RELATED INFORMATION
(HIPAA-Compliant Form)**

Name of Minor Child

Date of Birth

I, _____, the Parent/Legal Guardian of the minor child named above, hereby authorize (1) any physician, health care professional, dentist, mental health counselor, hospital, clinic or other medical facility, laboratory, pharmacy, Federal or State agency offering medical benefits, and any other health care agency or organization that has provided treatment, services, or benefits to my child, and (2) any teachers, guidance counselors, school nurses, and any other employees of any school that my child has attended and whom have provided treatment, services or benefits to my child to disclose, give and release, without restriction, all of my child's individually identifiable health information and medical records regarding any past, present or future medical, dental or mental health condition, including all information related to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse to Children's Volunteer Health Network, Inc. ("CVHN"), its directors, officers, employees, volunteers and agents.

This authority given to any director, officer, employee, volunteer or agent of CVHN shall supersede any prior arrangement that I may have made, on my child's behalf, with my child's health-care providers to restrict access to or disclosure of my child's individually identifiable health information. The individually identifiable health information and other medical records given, disclosed or release to any director, officer, employee, volunteer or agent of CVHN may be subject to redisclosure by such director, officer, employee, volunteer or agent of CVHN and may no longer be protected by HIPAA. The authority given to any director, officer, employee, volunteer or agent of CVHN herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my child's health-care provider. There are no exceptions to my right to revoke this HIPAA Release on behalf of my child.

Date _____

Signature of Parent/Legal Guardian

Date _____

Signature of Witness

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FAX

To:

From:

Fax:

Pages:

Phone:

Date:

Re:

Message:

*****TO BE COMPLETED BY ATTENDING DOCTOR/COUNSELOR*****

HEALTH CARE PROVIDER: Please fill in the areas below.

Fax the **completed form**, along with a **Walk Out Statement*** indicating the charges that *would have been* incurred with a **"NO CHARGE"** notation to 850-622-5434.

If immediate follow-up is needed (i.e. medication, further tests),
please call our office at 850-622-3200.

Findings/Diagnosis _____

Recommendations _____

Referred to _____

Primary Reason for Referral _____

Next Appointment: Date _____ Time _____

Signed by Doctor/Counselor _____ **Doctor signs here** Date _____

Unless otherwise specified by your recommendation and/or referral,
this is a one-time only appointment. If any follow-up appointments are needed, it is important that CVHN be notified
of each additional visit, along with the corresponding treatment plan.

*A detailed report listing all procedures performed and fees the patient would have been charged.



Dear Parent/Guardian and Client,

As the founder of Children's Volunteer Health Network, I want to welcome you and explain our program. As a faith based organization, we feel it is our privilege to serve and meet the needs of the uninsured and under-insured children in our area. We also believe, it is a partnership with our healthcare providers, and you as a recipient of those services benefiting your child. We all need to work together to make this a successful experience for everyone involved.

We have promised our *healthcare professionals* that we will do the following:

- CVHN will make and confirm all appointments with the providers.
- We will have all required paperwork filled out accurately and fully.
- We will follow up with the provider to make sure that all expectations were met from them, as well as the patients.
- On initial visits, we will send a volunteer with the parent/guardian and child to facilitate the visit.
- Unless requested by the provider, each appointment is a *one time only visit*.

As a recipient of these benefits, we require you to:

- Never be late for an appointment or not show up. This has a disastrous ripple effect on the entire program.
- Be courteous and polite to the providers and staff. Ask your child to do the same. Ungracious and rude behavior is not acceptable.
- If you feel you have a suggestion or an idea, please express it to the caseworker or director, *not the provider*. Positive feedback makes us all better.

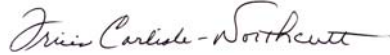
If you agree with these terms, then please sign at the bottom of this page. Have your child sign below your name.

Parent/Guardian _____

Client/child _____

*Our children are the hearts and future of this community.
They are our most precious resource.
Let's work together to keep these kids happy and healthy!*

May God Bless you,



Tricia Carlisle Northcutt

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Florida House of Representatives
Tallahassee, Florida 32399-1300
Statutes. State of Florida, Chapter 768.1355

768-1355 Florida Volunteer Protection Act.

1. Any person who volunteers to perform any service for any nonprofit organization, including an officer or director of such organization, without compensation, except reimbursement for actual expenses, shall be considered an agent of such nonprofit organization when acting within the scope of any official duties performed under such volunteer services. Such person shall incur no civil liability for any act or omission by such person which results in personal injury or property damage if:
 - a. Such person was acting in good faith within the scope of any official duties performed under such volunteer service and such person was acting as an ordinary reasonably prudent person would have acted under the same or similar circumstances; and
 - b. The injury or damage was not caused by any wanton or willful misconduct on the part of such person in the performance of such duties.
 1. For purposes of this act, the term "nonprofit organization" means any organization which is exempt from taxation pursuant to 26 U.S.C. s. 501, or any federal, state, or local governmental entity.
 2. For purposes of this act, the term "compensation" does not include a stipend as provided by the Domestic Service Volunteer Act of 1973, as amended (Pub. L. No. 93-113), or other financial assistance, valued at less than two-thirds of the federal hourly minimum wage standard, paid to a person who would otherwise be financially unable to provide the volunteer service.
2. Except as otherwise provided by law, if a volunteer is determined to be not liable pursuant to subsection (1), the nonprofit organization for which the volunteer was performing services when the damages were caused shall be liable for such damages to the same extent as the nonprofit organization would have been liable if the liability limitation pursuant to subsection (1) had not been provided.
3. Members of elected or appointed boards, councils, and commissions of the state, counties, municipalities, authorities, and special districts shall incur no civil liability and shall have immunity from suit as provided in s. 768.28 for acts or omissions by members relating to members' conduct of their official duties. It is the intent of the Legislature to encourage our best and brightest people to serve on elected and appointed boards, councils, and commissions.
4. This section may be cited as the "Florida Volunteer Protection Act".