Northcoast Children's Services Job Openings

TEACHER, Smith Lane, (EHS) ***Available now***
Responsible for development & implementation of classroom activities—providing support and supervision for a toddler program. Must have 12 core in ECE/CD (with 3 units in Infant/Toddler Development or Curriculum), and meet Associate Teacher Level on the Child Development Permit Matrix
P/T 28 hrs./wk. **$20.73-$22.86/hr. Open Until Filled.**

INTERPRETER, ASL, Fortuna, Eureka
Assist in interpreting in class, at parent meetings and on home visits for children and families. Bilingual ASL required. Must have 6 months' experience working with children and families. Prefer 6-12 units in Early Childhood Education. ***2 hours a week*** **$17.99-$19.83 Open Until Filled.**

FAMILY SERVICES SPECIALIST, Arcata Main Office ***Available Now***
Provides services to families in the Head Start and Early Head Start programs. Assists families in determining needs & identifying and developing goals to meet those needs. BA in Social Work, Psychology, Child Development, or a related field preferred. Prefer 2 years' experience in case management, home visiting, or working with at-risk families. **F/T M-Fri. *40 hrs*./wk. $23.04-$24.19/hr. Open Until Filled.**

LEAD TEACHER, Fortuna 1 Partnership ***Available now***
Responsible for the development & implementation of classroom activities for preschool children. Must have 12 core units in ECE/CD, meet Associate Teacher level on Child Development Permit Matrix or higher.
F/T $22.00-$23.10/hr. Open Until Filled.

Site Supervisor 1, NCSITC, Crescent City (EHS) ***Available Now***
Responsibilities include establishing classroom policies and procedures for children's development and safety. Ensure Center maintains proper license requirements. Provide leadership in conveying the mission and objectives of NCS and models a strength-based approach to communication, supervision, teamwork and support. For Site Supervisors working in an Infant and Toddler Center, three (3) units in Infant Toddler care are required. Also, must have AA in ECE, Psychology, Sociology or related field as well as a Site Supervisor Permit is also required. A minimum of 2 yrs. exp. working with preschool children in a group setting.
F/T 40 hr./wk. **(M-Fri); $ 27.69-$29.09 /hr. Open Until Filled**

LEAD TEACHER, CRITC Partnership ***Available now***
Responsible for the development & implementation of classroom activities for preschool children. Must have 12 core units in ECE/CD, meet Associate Teacher level on Child Development Permit Matrix or higher. Also three (3) units in Infant toddler care are desirable.
F/T $22.00-$23.10/hr. Open Until Filled.

Site Supervisor 1, Fortuna ***Available Now***
Responsibilities include establishing classroom policies and procedures for children's development and safety. Ensure Center maintains proper license requirements. Provide leadership in conveying the mission and objectives of NCS and models a strength-based approach to communication, supervision, teamwork and support. Must have AA in ECE, Psychology, Sociology or related field and a Site Supervisor Permit is required. Requires a minimum of 2 yrs. exp. working with preschool children. ***F/T 40 hr./wk.*** **(M-Fri); $ 27.69-$29.09 /hr. Open Until Filled**

Site Supervisor 1, CRITC, Arcata (EHS) Partnership ***Available Now***
Responsibilities include establishing classroom policies and procedures for children's development and safety. Ensure Center maintains proper license requirements. Provide leadership in conveying the mission and objectives of NCS and models a strength-based approach to communication, supervision, teamwork and support. For Site Supervisors working in an Infant and Toddler Center, three (3) units in Infant Toddler care are required. Also, must have AA in ECE, Psychology, Sociology or related field as well as a Site Supervisor Permit is also required. A minimum of 2 yrs. exp. working with preschool children in a group setting.
F/T 40 hr./wk. **(M-Fri); $ 27.69-$29.09 /hr. Open Until Filled**

CENTER DIRECTOR, EHS ***School Year 24/25***
Responsibilities include the overall management of a Head Start center base program. Must meet Teacher Level on Child Development Permit Matrix, plus 3 units in Administration (BA/BS Degree in Child Development or a related field preferred). Requires a minimum of 2 yrs. exp. working with preschool children in a group setting.
F/T 40 hr./wk. **(M-Fri); $24.47-$26.97/hr. Open Until Filled**

LEAD TEACHER, For Various Locations ***School Year 24/25***
Responsible for the development & implementation of classroom activities for preschool children. Must have 12 core units in ECE/CD, meet Associate Teacher level on Child Development Permit Matrix or higher.
F/T $22.00-$23.10/hr. Open Until Filled.

TEACHER, For Various Locations ***School Year 24/25***
Responsible for development & implementation of classroom activities—providing support and supervision for a toddler program. Must have 12 core in ECE/CD (with 3 units in Infant/Toddler Development or Curriculum), and meet Associate Teacher Level on the Child Development Permit Matrix
P/T & F/T **$20.73-$22.86/hr. Open Until Filled.**

HOME VISITOR, (Bilingual Preferred) Various Locations ***School Year 24/25***
Provide weekly home visits and facilitates parent & child playgroups. Requires AA/AS degree in Early Childhood Education, Psychology, Social Work or a related field OR 24 Head Start related units.
Bilingual preferred. F/T 40 hrs./wk $21.05-$22.10/hr Open Until Filled.

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Community Health Centers

Mobile Dental Van

Coming to the Blue Lake Community Resource Center June 2024

Dental Care For Children:

- Treatment provided: Exams (X-rays), cleanings, sealants, fillings, extractions.
- Follow up treatment will be completed at the Burre Dental Center.
- We recommend a dental check-up every 6 months.

Dental Care For Adults:

- Emergency care ONLY. This does NOT establish you as a patient at Open Door.
- A limited exam of 1-2 problem area(s) will be provided. Treatment will be set for a future visit.
- Emergency treatment for pain includes: Simple extractions, fillings, limited cleanings.

Important Information:

- **Prospective patients must complete a registration packet. Please attend one of our registration events to complete the required forms.**
- **Please provide a copy of your insurance and ID card. For non-insured, we offer an income-based sliding-fee-scale.**
- **Once required forms are submitted, Open Door will call to schedule an appointment.**
- ***For questions please call: (707) 407-7713***

Scan to download a registration packet.

Paper copies are available at the Blue Lake Community Resource Center.

Registration Events:

May 23rd or May 29th - 10:00am-1:00pm
Blue Lake Community Resource Center
111 Greenwood Ave, Blue Lake CA 95525

Humboldt Network of Family Resource Centers
HNFRC

Consent to Treatment, Assignment of Benefits & Release of Information

Name of Child: _____ Date of Birth: _____

Adult Providing Consent: _____ Relation to Child: _____

- If you do not want your child to be seen, please initial here _____ and return this form.
- With my signature below, I authorize Open Door Community Health Centers to provide diagnosis and/or treatment of dental conditions for the above-named child through the Mobile Dental Program.
- I understand that Open Door Community Health Centers will provide only those services that I have authorized below. I have signed next to each type of service for which I am granting authorization:

_____ **Dental Exam**, including dental x-rays

_____ **Preventive Services**: tooth cleaning, oral hygiene instruction, sealants, fluoride treatment

_____ **Restorative Services**: filling, stainless steel crown, pulpotomy, root canal *Anesthesia is used for these procedures*

_____ **Extraction of Primary Teeth**: Removal of primary (baby) teeth that can not be restored through other treatments. *Anesthesia may be used for this procedure.*

*If **extraction of permanent teeth** is recommended, a separate consent form will be required.*

- I understand that mobile dental visits are scheduled during school hours. I have checked one box below to indicate whether or not I want to present when my child is seen. ***I understand that there is insufficient room in the mobile dental van to allow me to be present in the treatment area, but that I may wait nearby during my child's visit(s).***

☐ I want to be present at all of my child's dental appointments.

☐ I want to be present only at my child's dental appointments for restorative services or extractions.

☐ I want to be present only at my child's dental appointments for extractions.

☐ I do not need to be present at my child's dental appointments.

If you have requested to be present, we will call you with dates and times of your child's appointments. Please provide contact information below:

Daytime phone number(s): _____

- I have received a copy of the Notice of Privacy Practices of Open Door Community Health Centers. I understand that Open Door Community Health Centers shares certain types of information with other health care providers, public agencies and payors, as a part of our health care operations. I understand that I have the right to request that specific information not be shared, and that I should request more information if I have questions or concerns.
- *For patients with Healthy Families or Medi-cal*: You must present your current Healthy Families or Medi-Cal card.
- I certify, under penalty of perjury, that the information provided is true and correct to the best of my knowledge.

Signature of Parent or Legal Guardian: _____ Date: _____

OPEN DOOR COMMUNITY HEALTH CENTERS **PATIENT INFORMATION**

Last Name: _____ **First Name:** _____ MI: _____

Social Security Number: _____ **Date of Birth**: _____

Address (mailing): _____ **City:** _____ **Zip Code:** _____

Address (street): _____ City: _____ Zip Code: _____

Telephone: _____ May we contact you at home? ☐ Yes ☐ No

Other Contact: ☐ Message ☐ Pager ☐ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Trans: Male to Female ☐ Trans: Female to Male

Other names you have used: _____

Are Interpreter Services Needed? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____

Where do you currently live?: ☐ In my home or apartment ☐ At a shelter ☐ Staying with others
☐ In transitional housing ☐ The street, a camp, under a bridge, or in a car

Migrant Status: ☐ Migrant ☐ Seasonal ☐ Neither **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Veteran Status: ☐ Yes ☐ No

Race: ☐ White ☐ Asian ☐ American Indian ☐ African American ☐ Pacific Islander ☐ Alaskan Native ☐ Unknown

Employer Name: _____ Phone #: _____

Emergency Contact Information (for patient, or for responsible party if patient is a minor):

Emergency Contact Name: _____ Phone #: _____

Relationship to Patient: ☐ Spouse ☐ Mother ☐ Father ☐ Grandparent ☐ Other _____

Other Contact ☐ Message ☐ Pager ☐ Cell Phone ☐ Email ☐ Confidential _____

Medi-Cal ID Number: _____ Issue Date: _____

Guarantor Information (The person responsible for payment, example: a parent for a patient under 18 years of age)

Last Name: _____ **First Name:** _____ MI: _____

Billing Address: ☐ same as above _____ City/Zip: _____

Relationship to patient: ☐ Parent ☐ Spouse ☐ Other: _____ **Social Security Number**: _____

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Telephone:** _____

Income information: *Information provided is used to offer discounts to you.*

Family Income: $_____ per ☐ Year ☐ Month ☐ Week # of persons in Family: _____
☐ Declined

Entered by: _____ **Date:** _____

Housing and Income Information

Sliding Fee Discount Program

opendoor Community Health Centers

Why we ask for this information

Open Door Community Health Centers receive grants and federal funding to support our services. Each year we must collect information about the communities we serve to share with our funders. By completing this form, you are helping us keep our funding so we can offer more services.

We combine your information with others and report it in summary form. We do not share any personal information or report data that could be used to identify you.

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1. Information about you and where you live

Name	**Birth date**	**MRN** *Office Use*

Are you a veteran? (Check one) ☐ Yes ☐ No

How do you describe where you live? (Check one)

- ☐ Live in a place I own or rent (house, apartment, condo, or townhouse)
- ☐ Live in someone else's place on a temporary basis ("couch surfing")
- ☐ Live in transitional housing (Arcata House or halfway house)
- ☐ Live somewhere as part of a program or treatment (hospital, hotel or motel, respite care, treatment program, jail)
- ☐ Live in emergency shelter
- ☐ Live unsheltered (in a tent, car, around buildings or bridges)

At any time in the last 12 months were you without a regular place to live? (Check one) ☐ Yes ☐ No

2. Information about the people in your household

Please list the names and birth dates of the people in your household. Your household includes people you live and share an income with.

Name	**Birth date**	**MRN** *Office Use*

3. Information about household income

What is your household income before taxes or deductions? This is the total amount earned by all members of your household, including you.

Examples of income (check all that apply):

- ☐ Wages or salary from employment or self-employment
- ☐ Other earnings from employment, such as tips or commissions
- ☐ Child Support
- ☐ Spousal Support
- ☐ Alimony
- ☐ Pension or Retirement income
- ☐ Social Security
- ☐ Disability payments
- ☐ Unemployment payments
- ☐ Any other source of income_____

Total household income: $_____

Is this income (Check one) ☐ Weekly ☐ Monthly ☐ Annually

4. Eligibility for sliding fee discount scale co-payment

Based on your household income reported above you may be eligible for a discount on the fees for your services.

If you are reporting no income above, you must describe your current means of support and/or living situation:

_____

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts.

5. Certification and signature

I declare that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

Signature: _____ Date: _____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount ☐ Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

Open Door Community Health Centers - Dental Health History

PLEASE ANSWER THE FOLLOWING QUESTIONS.
For Yes/No questions, **please mark each question individually.**
If you are uncertain how to respond to a question, please tell your dentist.

Patient Name *First*_____ *Last*_____Date of Birth_____Sex

☐ Male ☐ Female ☐ Transgender

1. When was your last dental visit? _____ When were your last dental X-Rays? _____ At what dentist or office? _____
2. When was your last medical exam? _____ Who is your medical doctor? _____
3. How is your health in general? ☐ Excellent ☐ Fair ☐ Good ☐ Poor
4. Do you smoke or use tobacco? ☐ No ☐ Yes If Yes: How many years? _____ How many packs per day? _____
5. Women: Are you currently pregnant or nursing? ☐ No ☐ Yes

6. Medical History: Have you ever had...

	No	Yes
A. Abnormal blood pressure (high or low)	☐	☐
B. Allergies (hay fever or environmental)	☐	☐
C. Arthritis	☐	☐
D. Back or Neck Injury/Pain	☐	☐
E. Blood disorder, anemia	☐	☐
1. Abnormal bleeding with surgery or trauma	☐	☐
2. Bruising easily	☐	☐
F. Cancer / Radiation /Chemotherapy therapy	☐	☐
G. Cardiovascular (heart) disease	☐	☐
1. Chest pain during/after exertion	☐	☐
2. Shortness of breath	☐	☐
3. Swelling of ankles or feet	☐	☐
4. Cardiac pacemaker/defibrillator	☐	☐
H. Congenital heart lesion/anomaly	☐	☐
I. Artificial heart valve or stent	☐	☐
J. Diabetes	☐	☐
K. Fainting spells	☐	☐
L. Hepatitis, A, B, C other jaundice or liver disease	☐	☐
M. HIV or AIDs	☐	☐
N. Hives or skin rash	☐	☐
O. Kidney trouble	☐	☐
P. Lung trouble, Asthma, Emphysema, Tuberculosis	☐	☐
Q. Persistent or bloody cough	☐	☐
R. Prosthetic (circle): Joint, implant, bone plate or screw	☐	☐
S. Seizures	☐	☐
T. Sinus problems	☐	☐
U. Stomach ulcer	☐	☐

7. Dental History: Do you *currently* have...

A. Bleeding gums	☐	☐
B. Clenching or grinding teeth	☐	☐
C. Teeth sensitive to hot or cold	☐	☐
D. Unpleasant odor or taste in mouth	☐	☐

8. If you are taking any medications, please list all medications you are taking on the Current Medications form.

9. Medications: Are you taking...

	No	Yes
A. Antibiotics or sulfa drugs	☐	☐
B. Anticoagulants (blood thinners)	☐	☐
C. Antihistamines	☐	☐
D. Aspirin	☐	☐
E. Bisphosphonate (for treatment of bones, etc.)	☐	☐
F. Cortisone or other steroids	☐	☐
G. Heart drugs, nitroglycerin, digitalis	☐	☐
H. Insulin or other diabetes drugs	☐	☐
I. Medicine for high blood pressure	☐	☐
J. Oral contraceptives	☐	☐
K. Tranquilizers	☐	☐
L. *Other medications (list on Medications form)*	☐	☐

☐ **Check here if not taking any medications.**

10. Allergies: Have you ever had a reaction to...

	No	Yes
A. Aspirin/Ibuprofen	☐	☐
B. Codeine or other narcotics	☐	☐
C. Iodine	☐	☐
D. Latex or rubber products	☐	☐
E. Local anesthetic	☐	☐
F. Penicillin or Amoxicillin	☐	☐
G. Other Antibiotics	☐	☐
H. Sedatives or tranquilizers	☐	☐
I. Sulfa drugs	☐	☐
J. *Other medications (list on Medications form)*	☐	☐

☐ **Check here if no known allergies.**

11. Have you ever been treated in a Hospital? (Y/N)

_____

_____

12. List other diseases or problems not listed:

_____

_____

- **I have read a copy of the bisphosphonate alert.**
- **I have read the above and have filled out this health history completely, to the best of my ability.**

Signature (of Patient or Responsible Party): _____ Date: _____

OFFICE USE ONLY

Review Date: _____ **Dentist:** _____ **Review Date:** _____ **Dentist:** _____

Open Door's Member Services Referral Form

ASSISTANCE IS FREE!

Humboldt:
Phone: (707) 269-7073
Fax: (707) 269-7045

Del Norte:
Phone: (707) 465-1988
Fax: (707) 465-1987

Member Services can help with:

- Applications for Health Care Benefits or Coverage
- Food resource assistance
- Health care access questions
- *And More!*

Date:

Name

Date of Birth:

Name of Parent/Guardian (if applicable)

Daytime Phone:

Email:

Address:

Referred From:

- ☐ Mobile Dental
- ☐ Open Door Site:
- ☐ Other:

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I,_____, acknowledge I have received from Open Door
Patient Name
Community Health Centers, a copy of the Dental Materials Fact Sheet dated October 2001.

*Patient Signature*_____ *Date*_____

The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist and not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic", porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials". A "Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 – 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Dental Materials Fact Sheet

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

** Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

Toxicity of Dental Materials

Dental Amalgam

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (4354%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

DENTAL AMALGAM FILLINGS

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages

- ♥ Durable; long lasting
- ♥ Wears well; holds up well to the forces of biting
- ♥ Relatively inexpensive
- ♥ Generally completed in one visit
- ♥ Self-sealing; minimal-to-no shrinkage and resists leakage
- ♥ Resistance to further decay is high, but can be difficult to find in early stages
- ♥ Frequency of repair and Replacement is low

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Contact with other metals may cause occasional, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

COMPOSITE RESIN FILLINGS

Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to replacement for broken teeth.

Advantages

- ♥ Strong and durable
- ♥ Tooth colored
- ♥ Single visit for filling
- ♥ Resists breaking
- ♥ Maximum amount of tooth preserved
- ♥ Small risk of leakage if bonded only to enamel
- ♥ Does not corrode
- ♥ Generally holds up well to the forces of biting depending on product used
- ♥ Resistance to further decay is Moderate and easy to find
- ♥ Frequency of repair or replacement is low to moderate

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel

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Community Health Centers

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to provide this information to all individuals that request and obtain services at Open Door Community Health Centers. We do this by posting a summary of this Notice in the reception area of each of our health centers, and by providing this Notice in our patient information packet. Should our privacy practices change in the future, we will notify patients by promptly posting our new policy and by making revised Notices available to all patients.

How we use information about you

- We ask each patient to complete a Consent to Treatment form. This consent gives us permission to use and disclose your individual information for healthcare and business operations. This means you allow us to share your information when it is needed to provide care, coordinate health services, and obtain payment for those services.
- We request from you only the information that we need for health care and business operations. This information includes your health history and basic personal information. Examples of this are your address, phone number, insurance information, social security number, and family income.
- We limit access to your information to those employees that need the information in order to do their jobs. For example, billing staff use your personal information in order to bill for services, but do not access your personal health history.
- We share information about you with others that are involved in your health care. For example, we send basic information (such as services received and diagnoses) to insurances or programs that pay for the services. Another example is when your health care provider refers you to a specialist. Your provider sends related sections of your medical history to the specialist. These types of disclosures are directly related to the health care that we provide or coordinate and are allowed under your Consent to Treatment.
- We disclose some information in very specific situations that are required by law for example to report abuse, violence or neglect, or to report communicable diseases.
- As part of our management and quality improvement programs, we group your information with that of other patients for analysis. When this is done, your personal information is removed and it is no longer linked to you.
- We are a part of a health care collaborative called OCHIN. A current list of OCHIN members is available at www.ochin.org. As a business associate of ours, OCHIN supplies information technology and related services to us and other OCHIN members. OCHIN also engages in quality assessment and improvement activities on behalf of its members. For example, OCHIN coordinates clinical review activities on behalf of participating members. They do this to establish best practice standards and access medical benefits from the use of electronic health record systems. OCHIN also helps members work together to improve the management of internal and external patient referrals. We may share your health information with other OCHIN members when necessary for health care operation purposes.

- We may participate in one or more health information exchanges (HIEs). HIEs may electronically share medical information for treatment, payment and health care operation purposes with other participants in the HIEs. HIEs allow your health care providers to quickly access and use medical information necessary for your treatment and other lawful purposes. The addition of your medical information in a HIE is voluntary and subject to your right to opt-out. More information on any HIE in which we participate or how you can exercise your right to opt-out can be found at: https://www.nchiin.org/Optout.aspx

When we need your permission to disclose information

Any release of information about you that does not fall into the above categories requires a written authorization from you. You will be asked to complete an Authorization to Release form and to tell us exactly what sections of your information we can release, and to whom. If this form in not correct and complete, we can not release your individual information.

Your Rights Concerning your individual information

You have certain specific rights to control your individual health information. These rights are summarized below. We have policies and procedures in place regarding each of these items. You may contact your provider, or a medical records supervisor, for more information about any of these rights.

- **Right to revoke authorization** - You have the right to revoke a previously made authorization to release.
- **Right to request restrictions on disclosure** – You have the right to request that we not disclose all or part of your individual information, even for the health care and business operations discussed above. As a health care provider, we are not required to agree to your request, and we do not encourage any restriction that would impact the sharing of information that is important to maintaining your health. However, there may be situations when such a restriction is appropriate. You are encouraged to discuss this with your health care provider who will provide you with more information should a restriction be necessary.
- **Right to access your health care records** - You have the right to inspect your health care records in the presence of a health care provider, and to have a copy of those records.
- **Right to amend or correct your health care records** – You have the right to provide a written addendum to correct any portion of your health care record that you feel is inaccurate.
- **Right to know how your records have been disclosed** - You have the right to receive a history of the disclosures of your health care records.

What to do if you suspect that your privacy has been violated

We encourage our staff to report any suspected privacy violations, either intentional or unintentional. We also encourage you to make a report any time that you feel your privacy may have been violated. No individual will ever be discriminated against for making a report.

You may make a report in the following ways:

- Phone: (707) 826-8633 x 5176
- Fax a report to: (707) 445-0289 Attn: Privacy Officer
- Email: privacyofficer@opendoorhealth.com
- Send a written report to: Open Door Community Health Centers
  Attn: Privacy Officer
  1275 8th Street
  Arcata, CA 95521

Open Door Community Health Centers **MOBILE DENTAL**

Consentimiento para Tratamiento, Asignación de Beneficios & Revelación de Información

Nombre del Paciente Menor: _____ Fecha de nacimiento: _____

Nombre del Adulto que da consentimiento: _____ Relación: ☐ Padre ☐ Guardián Legal

- Si no quiere ningún servicios dentales para su niño, favor de firmar aquí _____ y mandar esto formulario a la escuela.
-
- Con mi firma abajo, doy autorización al Programa Dental Móvil de Open Door Community Health Centers para el diagnóstico y/o tratamiento dental para el paciente menor nombrado arriba.

- Entiendo que el Programa Dental Móvil de Open Door Community Health Centers puede proveer solamente los servicios que autorizo abajo. He firmado en la linea por cada tipo de servicio que autorizo:

_____ **Examen Dental**, incluyendo examen de rayos-X

_____ **Servicios preventivos**: profilaxis, instrucción de salud oral, selladores, tratamiento con fluororo

_____ **Servicios restorativos**: el empaste, corona metálica, pulpotomia, tratamiento de canal radicular. *Usamos la anestesia durante estos tratamientos.*

_____ **Extracción de Dientes Primarias**: Extracción de dientes primarias (dientes del niño) que no pueden ser restorados por otros tratamientos. *Aveces usamos la anestesia durante esto tratamiento.*

*Si la dentista recomenda **extracción de dientes permanentes,** ud. va a recibir otro formulario de consentimiento.*

- Entiendo que los servicios de la clínica dental móvil son durante las horas escolares. He escogido una de las cajas abajo para indicar si quiero estar a la escuela durante la cita de mi niño. Entiendo que no hay bastante espacio para estar en el cuarto de tratamiento con mi niño, pero que puedo esperar acerca durante la cita.

☐ Quiero ser presente durante todas las citas de mi niño.

☐ Quiero ser presente solamente durante las citas que incluyen servicios restorativos o extracciones.

☐ Quiero ser presente solamente durante las citas que incluyen servicios extracciones.

☐ No es necesario que soy presente durante las citas de mi niño.

Si quiere ser presente, vamos a llamar con las fechas y horas de las citas de su niño. Favor de dar los números teléfonos adonde debemos llamar:

Números teléfonos (del día): _____

- He recibido La Noticia que describe el uso de informacion personal medical. Entiendo que Open Door Community Health Centers compartira ciertos tipos de información con otros centros médicos, practicantes médicos y pagadores, como un parte normal de nuestros negocios. Entiendo también que tengo el derecho a pedir que no séa compartida cierta información, y que debo pedir más información si estoy preocupado o tengo preguntas.
- Para pacientes con aseguranza de Healthy Families o Medi-Cal: es necesario presenter su tarjeta de Healthy Families o Medi-Cal más reciente.
- Doy fe bajo la pena de perjurio que la información es verdadera y corecta según mi leal entender y saber.

Firma: _____ Fecha: _____

OPEN DOOR COMMUNITY HEALTH CENTERS **INFORMACIÓN DEL PACIENTE**

Apellido: _____ **Primer Nombre:** _____

Número de Seguro Social: _____ **Fecha de nacimiento:** _____

Dirección (para correo): _____ Ciudad: _____ Código Postal: ____

Dirección (de casa): _____ Ciudad: _____ Código Postal: ____

Número de teléfono: _____ ¿Podemos contactarle en casa? ☐ Sí ☐ No

Otro método de contacto ☐ Teléfono de casa ☐ Teléfono móvil ☐ ☐ Correo electrónico _____

Sexo: ☐ Hombre ☐ Mujer **Otros nombres** que ha usado: _____

Su Lenguaje: ☐ Inglés ☐ Español ☐ Hmong ☐ Otro _____
¿Necesita servicios de interpretación? ☐ Sí ☐ No

Origen Étnico: ☐ Hispano ☐ No Hispano

Raza: ☐ Blanco ☐ Asiático ☐ Americano Nativo ☐ Afroamericano ☐ De Islas Pacíficas ☐ Nativo de Alaska ☐ No se sabe

Estatus migratorio: ☐ Inmigrante ☐ Trabajador temporal ☐ Ninguno de esos

Situación de vivienda: ☐ Ahora tengo hogar ☐ Sin Hogar ☐ Riesgo de perder mi hogar
☐ Vivo en un refugio ☐ Vivo con otras personas ☐ Vivo en la calle, campamento, puente ☐ Hogar temporal

¿Es Veterano militar? ☐ Sí ☐ No

Nombre de Empleador: _____ Teléfono: _____

Contactos en caso de emergencia (para el paciente, o para el padre/guardián si el paciente es menor de edad)

Nombre de contacto en caso de emergencia: _____ Teléfono: _____

Relación con el paciente ☐ Esposa/o ☐ Mamá ☐ Papá ☐ Abuelos ☐ Otro _____

Otro método de contacto ☐ Teléfono de casa ☐ Teléfono móvil ☐ ☐ Correo electrónico _____

Número de Medi-Cal: _____ Fecha de emisión: _____

Información del fiador (La persona que paga los cobros, por ejemplo: El padre de un paciente menor de edad.)

Apellido: _____ **Primer Nombre:** _____

Dirección: ☐ La misma descrita arriba _____ Ciudad/Código Postal: _____

Relación al paciente: ☐ Padre ☐ Esposo/a ☐ Otro: _____ **Numero de Seguro Social:** _____

Sexo ☐ Hombre ☐ Mujer **Fecha de nacimiento**: _____ **Teléfono:** _____

Datos Sobre Ingresos: *Usamos esta información para la escala de descuentos.*

Ingreso de familia: $_____ por: ☐ Año ☐ Mes ☐ Semana # de personas en la familia: _____
☐ Prefiero omitir esa información.

Entered by: _____ **Date:** _____

Información de Vivienda e Ingreso

Programa de descuento de tarifa variable

opendoor Community Health Centers

¿Por qué pedimos esta información?

Los Centros de Salud Comunitarios Open Door reciben subsidios y fondos federales para apoyar nuestros servicios. Cada año debemos recopilar información sobre las comunidades que servimos para compartir con nuestros financiadores. Al completar este formulario, nos está ayudando a mantener nuestros fondos para que podamos ofrecer más servicios.

Combinamos su información con otras y la informamos en forma resumida. No compartimos ninguna información personal ni informamos datos que puedan usarse para identificarlo.

---

1. Información sobre usted y dónde vive

Nombre	**Fecha de nacimiento**	**Uso de MRN** Office

¿Es usted un veterano? (Marque uno) ☐Sí ☐No

¿Cómo describe el lugar dónde vive? (Marque uno)

- ☐ Vive en su propia casa o renta (casa, apartamento o condominio)
- ☐ Vive con otra persona de forma temporal ("por ejemplo, durmiendo en el sofá en la casa de otra persona")
- ☐ Vive en una vivienda de transición (Casa Arcata u otra casa de transición)
- ☐ Vive en algún lugar como parte de un programa o tratamiento (hospital, hotel o motel, cuidado de relevo, programa de tratamiento, cárcel)
- ☐ Vive en un refugio de emergencia
- ☐ Vive desprotegido (en una tienda de campaña, automóvil, alrededor de edificios o puentes)

¿En algún momento de los últimos 12 meses estaba sin un lugar regular para vivir?
(Marque uno) ☐Sí ☐No

2. Información sobre las personas en su hogar

Por favor, enumere los nombres y fechas de nacimiento de las personas en su hogar. Su hogar incluye a las personas con las que vive y con las que comparte un ingreso.

Nombre	**Fecha de nacimiento**	**Uso de MRN** Office

3. Información sobre los ingresos del hogar

¿Cuál es el ingreso de su hogar antes de impuestos o deducciones? Esta es la cantidad total ganada por todos los miembros de su hogar, incluyéndolo a usted.

Ejemplos de ingresos (marque todos los que correspondan):

- ☐ Salarios o salarios del empleo o del trabajo por cuenta propia
- ☐ Otras ganancias del empleo, como propinas o comisiones
- ☐ Manutención de los hijos
- ☐ Manutención conyugal
- ☐ Cualquier otra fuente de ingreso_____
- ☐ Pensión alimenticia
- ☐ Pensión o ingresos de jubilación
- ☐ Seguridad social
- ☐ Pagos por discapacidad
- ☐ Pagos por desempleo

Ingreso total del hogar: $_____

¿Es este ingreso? (Cheque uno) ☐ Semanal ☐ Mensual ☐ Anual

4. Elegibilidad para el copago de la escala de descuento de tarifas proporcionales

Según los ingresos de su hogar informados anteriormente, puede ser elegible para un descuento en las tarifas de sus servicios.

Si no reporta ningún ingreso arriba, debe describir su medio actual de manutención y / o situación de vida:

_____

Nos reservamos el derecho de solicitar evidencia de sus ingresos en forma de talones de pago, declaraciones de impuestos u otros documentos para calificar para descuentos.

5. Certificación y firma

Declaro que la información que he dado en este formulario es verdadera, correcta y completa. Entiendo que la entrega de información falsa puede hacerme inelegible para servicios con descuento.

Firma_____ Fecha: _____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount ☐Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

Open Door Community Health Centers - Historia de Salud – Clínica Dental
FAVOR DE CONTESTAR LAS SIGUIENTES PREGUNTAS.
Marque cada respuesta de Sí o No individualmente por favor.
Si esta incierto a responder a una pregunta, por favor informe a su dentista.

Nombre _____ Apellido _____ Fecha de Nacimiento _____
Sexo ☐ Hombre ☐ Mujer ☐ Transgénero

3. ¿Cuándo fue su última visita al dentista? _____ ¿Cuándo fue sus últimas radiografías? _____ ¿Nombre del dentista o clinica? _____
4. ¿Cuándo fue su último examen médico? _____ ¿Nombre de su doctor? _____
3. ¿Cómo es su salud en general? ☐ Excelente ☐ Más o menos ☐ Bien ☐ Pobre
4. ¿Ústed fuma o usa tabaco? ☐ No ☐ Sí Si marco si ¿por cuántos años? _____ ¿Cuántos paquetes al día? _____
5. Mujeres: ¿Está ústed embarazada o amamentando? ☐ No ☐ Sí

6. Historia Médica: Tiene o ha tenido...

	No	Sí
A. Abnormal presión de la sangre (alta o baja)	☐	☐
B. Alergias (fiebre del heno o medio ambiente)	☐	☐
C. Artritis	☐	☐
D. Dolor de espalda o cuello	☐	☐
E. Trastorno de la sangre, anemia	☐	☐
1. Sangrado abnormal con cirugía o trauma	☐	☐
2. Salen moretones facilmente	☐	☐
F. Cancer / radiación / quimioterapia	☐	☐
G. Cardiovascular (Corazón) enfermedad	☐	☐
1. Dolor del pecho durante/o después de esfuerzo	☐	☐
2. Falta de respiración	☐	☐
3. Hinchazón de tobillos o pies?	☐	☐
4. Marcapasos cardiaco/desfribrilador	☐	☐
H. Lesión cardíaca/anomalia	☐	☐
I. Válvulas del Corazón artificial o stent	☐	☐
J. Diabetis	☐	☐
K. Desmayos	☐	☐
L. Hepatitis, A, B, C otros ictericia o enfermedades del higado	☐	☐
M. VIH o SIDA	☐	☐
N. Urticarias o erupción de la piel	☐	☐
O. Complicaciones del riñon	☐	☐
P. Complicaciones del pulmon,asma,enfisema,tuberculosis	☐	☐
Q. Persistente o tos con sangre	☐	☐
R. Protesis (circule): conyunturas, implante, place de hueso o tornillos	☐	☐
S. Convulciones	☐	☐
T. Problemas de sinusitis	☐	☐
U. Úlceras de estómago	☐	☐

7. Historia Dental: Al momento tiene...

A. Encias sangrantes	☐	☐
B. Tendencia de apretar o rechinar los dientes	☐	☐
C. Dientes sensibles a caliente o frío	☐	☐
D. Olor o sabor desagradable en la boca	☐	☐

8. Si ústed esta tomando medicamentos, por favor liste todas las medicinas que ústed este tomando en nuestra forma de medicamentos.

9. Medicamentos: Esta tomando...

	No	Sí
A. Antibióticos o sulfas	☐	☐
B. Anticoagulantes (adelgazadores sanguíneos)	☐	☐
C. Antihistaminicos	☐	☐
D. Aspirina	☐	☐
E. Bisfosfonato (tratamiento de huesos)	☐	☐
F. Cortisona o otros esteroides	☐	☐
G. Medicamento del Corazon, nitroglicerina, digital	☐	☐
H. Insulina o otras medicamentos de diabetis	☐	☐
I. Medicamentos de alta presión	☐	☐
J. Toma anticonseptivos	☐	☐
K. Tranquilizantes orales	☐	☐
L. Otros medicamentos (liste en nuestra forma de medicamentos)	☐	☐

☐ **Marke aqui si no esta tomando ningún medicamento.**

10. Alergias: Ha tenido reacción adverso a...

	No	Sí
A. Aspirina/Ibuprofen	☐	☐
B. Codeina o otros narcóticos	☐	☐
C. Yodo	☐	☐
D. Latex o otros productos de hule	☐	☐
E. Anestecia locales	☐	☐
F. Penicilina o amoxicilina	☐	☐
G. Otros antibioticos	☐	☐
H. Tranquilizantes o sedantes	☐	☐
I. Sulfamido	☐	☐
J. Otros medicamentos (liste en nuestra forma de medicamentos)	☐	☐

☐ **Marque aquí si usted sabe que no tiene alergias.**

11. Ha recibido tratamiento en un hospital? (Si/No)

_____
_____

12. Liste otros problemas o enfermedades:

_____
_____

- **He leído la alerta acerca de los bisfosfonatos.**
- **He leído lo de arriba y he contestado este cuestionario a mi major habilidad.**

Firma del Paciente o del Tutor legal (por paciente menor): _____ Fecha: _____

---------- SOLAMENTE POR EL USO DEL DENTISTA ----------

Review Date: _____ **Dentist:** _____ **Review Date:** _____ **Dentist:** _____

Open Door's Servicios para Miembros Formulario

¡ASISTENCIA ES GRATIS!

Humboldt:
Teléfono: (707) 269-7073
Fax: (707) 269-7045

Del Norte:
Teléfono: (707) 465-1988
Fax: (707) 465-1987

Nuestro Servicios para Miembros les puede ayudar con:

- Aplicaciones para cubertura o beneficios de cuidado de salud
- Asistencia recursos alimenticos
- Preguntas sobre acceso al cuidado de la salud
- *¡Y Más!*

Fecha:

Nombre

Fecha de Nacimiento:

Nombre del padre o guardián (si es aplicable):

Número de teléfono durante el día:

Correo electrónico:

Dirección:

Referred From/
Sitio de Referencia:

- ☐ Mobile Dental
- ☐ Open Door Site:
- ☐ Other:

Reconocimiento del paciente de haber recibido la Joja de Materias Dentales

Yo (nombre del paciente) _____, reconozco que he recibido de la Clínica Dental de Open Door Community Health Centers una copia de la

Hoja de Materias Dentales con fecha de octubre 2001.

La Firma del paciente: _____ Fecha: _____

El documento siguiente es la Joja de Materias Dentales de la Junta Odontológica de California. El Departamento de Asuntos del Consumidor no tiene ninguna posición con respecto al asunto de esta Joja de Materiales Dentales y su acoplamiento al website de CDA no constituyé un respaldo del contenido de este documento.

Junta Odontológica de California
Hoja de Materiales Dentales Adoptada el 17 de octubre 2001

Como requerido por el Capítulo 801 de los Estatutos de 1992, la Junta Odontológica de California ha preparado esta hoja para resumir la información en las materias reconstituyentes dentales más frecuentemente usadas. La información en esta hoja está ofrecida para alentar la discussion entre el paciente y el dentista con respecto a la selección de materias dentales major acomodadas par alas necesidades dentales del paciente. No está hecha para ser una guía completa a la ciencia de materias dentales.

Las materias usadas más frecuentemente en el tratamiento reconstituyente dentalson: amalgama, resina compuesta, cemento de crystal del ionomer, cemento de ionomer de resina, porcelana (cerámica) porcelana (fundida al metal), aleaciones de oro (metal noble) y aleaciones de cromo-cobalto o níquel (metal común). Cada material tiene sus propias ventajas y desventajas, beneficios y riesgos. Estos y otros factores pertinentes se comparan en la matriz adjunta, titulada Las Comparaciones de Materias Reconstituyentes Dentales. Un Glosario de terminus usados.

Las declaraciones hechas son sostenidas por investigaciones dentales, creíbles y pertinentes, publicadas principalmente entre 1993 y 2001. En algunos casos, donde investigación contemporánea es escasa, hemos indicado nuestras mejores percepciones basadas sobre la informaciónfechada antes del 1993.

Se avisa al lector que el resultado del tratamiento o la durabilidad de una restauración no es unicamente una function de la material. La durabilidad de cualquiera restauración es influída por la técnica del dentista al colocar la restauración , las materias ancilares empleadas en el procedimiento, y la cooperación del paciente durante el procedimiento. Después de la restauración de los dientes, la longevidad de la restauración sera influenciada fuertemente por la conformidad de los pacientes con la hygiene dental y el cuidado casero, su dieta y los hábitos de la masticación.

Tanto la profesión pública como la dental se preócupan por la seguridad del tratamiento dental y de cualquier riesgo potencial de salud que se pudiera asociar a los materials usados para restablecer los dientes. Todos los materials usados (y enumerados comunmente en esta joja se han mostrado – por medio de investigación clínica y laboratorio, así como por uso clínico extensor directo – de ser seguros y eficaces para la población en general. La presencia de estas materias en los dientes no causa problemas adversos de la salud para la mayoría de la población. Existen una diversidad de opinions científicas con respecto a la seguridad de las amalgamas dentales del mercurio. La literatura de investigación en diarios cientificos revisados sugiere que las mujeres, los niños, y los diabéticos de otra manera sanos no están en el riesgo aumentado por consecuencia de la exposición al mercurio de las amalgamas dentales. Aunque hay varias opinions tocante al riesgo de mercurio en el embarazo, en la diabetes, y en los niños, estas opinions no son cientificamente conclusivas y por lo tanto el dentista puede discutir estas opinions con sus pacientes. No hay la evidencia de investigación sugeriendo que las mujeres embarazadas, los diabéticos y los niños están en el riesgo aumentado de la salud debido a rellenos de amalgama en la boca. Un studio reciente informado en el JADA (Journal of the American Dental Association) especifica una tolerancia reducida (1/50111 del límite de venta especificado por la World Health Organization) para la exposición a calcular la cantidad de mercurio que quizás sea tomado de rellenos dentales. Este nivel cae debajo los límites establecidos para la exposición a una concentración baja de mercurio o cualquier otro componente liberado de una material reconstituyente dental. Así que, mientras estos subconjuntos de la población pueden ser percibidos para estar en el riesgo aumentado de la salud pore star expuestos al reconstituyente dental, la prueba científica no sostiene esta propuesta.

1ENERO de 2002

UNA COPIA DE ESTE RECONICIMIENTO
SERA COLOCADA EN EL ARCHIVO DEL PACIENTE

opendoor
Community Health Centers

AVISO DE PRÁCTICAS DE PRIVACIDAD

ESTE AVISO DESCRIBE COMO SU INFORMACIÓN MÉDICA PUEDE SER UTILIZADA Y DIVULGADA Y COMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN.
POR FAVOR LÉA EL AVISO CUIDADOSAMENTE.

Estamos obligados por ley a proporcionar esta información a todas las personas quienes soliciten y obtengan servicios en Los Centros Comunitarios De Salud De Open Door. Hacemos esto por medio de la publicación de un resumen de este aviso en la recepción de cada uno de nuestros centros de salud y también dando esta notificación en nuestro paquete de información para el paciente. En caso de que nuestras prácticas de privacidad cambien en el futuro, notificaremos a los pacientes con publicar inmediatamente nuestra nueva política y con hacer avisos revisados disponibles a todos los pacientes.

Cómo usamos su información personal

- Le pedimos a cada paciente llenar un formulario para Consentimiento de Tratamiento. Esta autorización nos da permiso para usar y divulgar su información individual para las operaciones comerciales y de atención médica. Esto significa que nos permite compartir su información cuando sea necesario darle atención médica, coordinar sus servicios de salud y obtener el pago de estos servicios.
- Solicitamos de usted sólo la información que necesitamos para el cuidado de su salud y las operaciones comerciales. Esta información incluye su historial de salud e información personal básica. Ejemplos de esto son su dirección, número de teléfono, información de su seguro de salud, número de seguro social e ingresos familiares.
- Limitamos el acceso a su información a aquellos empleados quienes necesiten su información para hacer su trabajo. Por ejemplo, personal de facturación utiliza su información personal para facturar servicios, pero no acceder a su historial de salud personal.
- Compartimos información sobre usted con otras personas quienes participen en el cuidado de su salud. Por ejemplo, enviamos información básica (tales como servicios que usted ha recibido y diagnósticos) a seguros de salud o programas que pagan por los servicios. Otro ejemplo es cuando el médico lo refiere a un especialista. Su proveedor envía secciones relacionadas de su historia clínica personal al especialista. Estos tipos de divulgación de información personal están directamente relacionados con la atención médica que brindamos o coordinamos y se permiten mediante su consentimiento al tratamiento.
- Revelamos algunos datos en situaciones muy específicas que son requeridas por ley, por ejemplo: abuso, violencia o negligencia, o para reportar enfermedades transmisibles.
- Como parte de nuestra administración y programas de mejoramiento de nuestra calidad, agrupamos su información con la de otros pacientes con fines de análisis. Una vez terminado el proceso, su información personal se elimina, obteniendo así un reporte sin información acerca de usted.
- Somos parte de un colaborador del cuidado de la salud llamado OCHIN. Una lista actualizada de miembros de OCHIN está disponible en www.ochin.org. Como socio nuestro, OCHIN nos suministra tecnología informática y servicios relacionados a nosotros y a otros miembros de OCHIN. OCHIN también participa en la evaluación de la calidad y actividades de mejoramiento en nombre de sus miembros. Por ejemplo, OCHIN coordina la revisión de actividades clínicas en nombre de los miembros participantes. Lo hacen para establecer mejores estándares de práctica y para tener acceso a beneficios médicos de la utilización de sistemas de registro electrónico de la salud. OCHIN también ayuda a los miembros a trabajar juntos para mejorar el manejo de referencias internas y

externas de los pacientes. Podemos compartir su información médica con otros miembros de OCHIN cuando sea necesario para fines de operaciones de atención médica.

- Podemos participar en uno o más intercambios de información de salud (HIEs por sus siglas en Ingles). HIEs puede compartir información médica electrónicamente con propósitos de tratamiento, pagos, y cuidado de salud con otros participantes de HIEs. HIEs le permite a los médicos acceder rápidamente y utilizar información médica necesaria para su tratamiento y otros fines legales. La adición de su información médica en una HIE es voluntaria y usted tiene el derecho de no participar si así lo desea. Sobre cualquier HIEs en las que participamos o cómo puede ejercer su derecho a no optar, puede encontrar toda la información en: https://www.nchiin.org/Optout.aspx

¿En que casos necesitamos su permiso para divulgar información?

Cualquier divulgación de información sobre usted que no caiga en las categorías anteriores requiere de usted una autorización por escrito. Se le pedirá completar un formulario de Autorización para Divulgar Información y decirnos exactamente qué secciones de su información podemos divulgar y a quien. Si este formulario no se completa o se corrige, no podemos compartir su información personal.

Sus derechos con respecto a su información personal

Usted tiene ciertos derechos específicos para el control de su información de salud personal. Estos derechos se resumen a continuación. Contamos con políticas y procedimientos con respecto a cada uno de estos elementos. Puede contactar a su proveedor de salud, o aun supervisor de registros médicos, para obtener más información acerca de cualquiera de estos derechos.

- **Derecho a revocar la autorización** - usted tiene el derecho de revocar un formulario de Autorización para Divulgar Información que haya llenado anteriormente.
- **Derecho a solicitar restricciones sobre la revelación –** usted tiene derecho a solicitar que no revelamos todo o parte de su información personal, incluso para el cuidado de la salud y operaciones mencionadas. Como médicos, no estamos obligados a aceptar su petición, y no alentamos cualquier restricción que pudiera impactar el intercambio de información que es importante para mantener su salud. Sin embargo, puede haber situaciones en las que es apropiada tal limitación. Le animamos a discutir esto con su médico quien le proporcionara más información si una restricción es necesaria.
- **Derecho a acceder a sus registros de salud** - usted tiene el derecho de inspeccionar sus registros de salud en presencia de un médico y tener una copia de los registros.
- **Derecho a modificar o corregir sus registros de atención de salud –** usted tiene derecho de proporcionar una adenda escrita para corregir alguna parte de su expediente médico que sienta que es inexacta.
- **Derecho a conocer cómo sus registros han sido revelados** - usted tiene el derecho a recibir una copia del historial de las divulgaciones de sus registros de salud.

Qué hacer si usted sospecha que su privacidad ha sido violada

Animamos a nuestro personal para reportar cualquier violación de privacidad sospechosa, ya sea intencional o no intencional. También le animamos hacer un informe cada vez que sienta que su privacidad ha sido violada. Nadie será víctima de represalias por elaborar un reporte.

Usted puede hacer un informe de las siguientes maneras:

- Teléfono: (707) 826-8633 x 5176
- Fax: (707) 445-0289 Attn: Privacy Officer
- Email: privacyofficer@opendoorhealth.com
- Envíe un reporte escrito a: Open Door Community Health Centers
  Attn: Privacy Officer
  1275 8th Street
  Arcata, CA 95521

OPEN DOOR COMMUNITY HEALTH CENTERS **PATIENT INFORMATION**

Last Name: _____ **First Name:** _____ MI: _____

Social Security Number: _____ **Date of Birth:** _____

Address (mailing): _____ **City:** _____ **Zip Code:** _____

Address (street): _____ City: _____ Zip Code: _____

Telephone: _____ May we contact you at home? ☐ Yes ☐ No

Other Contact: ☐ Message ☐ Pager ☐ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Trans: Male to Female ☐ Trans: Female to Male

Other names you have used: _____

Are Interpreter Services Needed? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____

Where do you currently live?: ☐ In my home or apartment ☐ At a shelter ☐ Staying with others ☐ In transitional housing ☐ The street, a camp, under a bridge, or in a car

Migrant Status: ☐ Migrant ☐ Seasonal ☐ Neither **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Veteran Status: ☐ Yes ☐ No

Race: ☐ White ☐ Asian ☐ American Indian ☐ African American ☐ Pacific Islander ☐ Alaskan Native ☐ Unknown

Employer Name: _____ Phone #: _____

Emergency Contact Information (for patient, or for responsible party if patient is a minor):

Emergency Contact Name: _____ Phone #: _____

Relationship to Patient: ☐ Spouse ☐ Mother ☐ Father ☐ Grandparent ☐ Other _____

Other Contact ☐ Message ☐ Pager ☐ Cell Phone ☐ Email ☐ Confidential _____

Medi-Cal ID Number: _____ Issue Date: _____

Guarantor Information (The person responsible for payment, example: a parent for a patient under 18 years of age)

Last Name: _____ **First Name:** _____ MI: _____

Billing Address: ☐ same as above _____ City/Zip: _____

Relationship to patient: ☐ Parent ☐ Spouse ☐ Other: _____ **Social Security Number:** _____

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Telephone:** _____

Income information: *Information provided is used to offer discounts to you.*

Family Income: $_____ per ☐ Year ☐ Month ☐ Week # of persons in Family: _____
☐ Declined

Entered by: _____ **Date:** _____

Housing and Income Information

Sliding Fee Discount Program

opendoor Community Health Centers

Why we ask for this information

Open Door Community Health Centers receive grants and federal funding to support our services. Each year we must collect information about the communities we serve to share with our funders. By completing this form, you are helping us keep our funding so we can offer more services.

We combine your information with others and report it in summary form. We do not share any personal information or report data that could be used to identify you.

---

1. Information about you and where you live

Name	**Birth date**	**MRN** *Office Use*

Are you a veteran? (Check one) ☐ Yes ☐ No

How do you describe where you live? (Check one)

- ☐ Live in a place I own or rent (house, apartment, condo, or townhouse)
- ☐ Live in someone else's place on a temporary basis ("couch surfing")
- ☐ Live in transitional housing (Arcata House or halfway house)
- ☐ Live somewhere as part of a program or treatment (hospital, hotel or motel, respite care, treatment program, jail)
- ☐ Live in emergency shelter
- ☐ Live unsheltered (in a tent, car, around buildings or bridges)

At any time in the last 12 months were you without a regular place to live? (Check one) ☐ Yes ☐ No

2. Information about the people in your household

Please list the names and birth dates of the people in your household. Your household includes people you live and share an income with.

Name	**Birth date**	**MRN** *Office Use*

3. Information about household income

What is your household income before taxes or deductions? This is the total amount earned by all members of your household, including you.

Examples of income (check all that apply):

- ☐ Wages or salary from employment or self-employment
- ☐ Other earnings from employment, such as tips or commissions
- ☐ Child Support
- ☐ Spousal Support
- ☐ Any other source of income_____
- ☐ Alimony
- ☐ Pension or Retirement income
- ☐ Social Security
- ☐ Disability payments
- ☐ Unemployment payments

Total household income: $_____

Is this income (Check one) ☐ Weekly ☐ Monthly ☐ Annually

4. Eligibility for sliding fee discount scale co-payment

Based on your household income reported above you may be eligible for a discount on the fees for your services.

If you are reporting no income above, you must describe your current means of support and/or living situation:

_____

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts.

5. Certification and signature

I declare that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

Signature: _____ Date: _____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**

☐ Not Eligible for Sliding Scale Discount ☐ Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

OPEN DOOR COMMUNITY EALT CENTERS
PATIENT HISTORY

Patient's ame: MRN: Date of Birth:

MEDICAL HISTORY: Have you ever had any of these conditions? Please check YES on all conditions that apply to you. Use the comment section below for further explanation.

Condition	Y	N	Condition	Y	N	Condition	Y	N
Abuse as Adult	☐	☐	Depression	☐	☐	Meningitis	☐	☐
Abuse as Child	☐	☐	Diabetes	☐	☐	Mental Health Disorder	☐	☐
ADD/ADHD	☐	☐	Drug Addiction	☐	☐	MRSA History of Infection	☐	☐
Alcoholism	☐	☐	Emphysema/COPD	☐	☐	Myocardial Infarction	☐	☐
Allergies	☐	☐	Glaucoma	☐	☐	Nerve/Muscle Disease	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐	Osteoporosis	☐	☐
Anxiety	☐	☐	Heart Failure	☐	☐	Pacemaker	☐	☐
Arthritis/ Joint Disorder	☐	☐	Heart Murmur	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Heart Endocarditis	☐	☐	Sickle Cell Anemia	☐	☐
Autism	☐	☐	History of Blood Transfusion	☐	☐	STD	☐	☐
Broken Jaw	☐	☐	HIV/AIDS	☐	☐	Stomach Ulcers	☐	☐
Cancer	☐	☐	Hyperlipidemia	☐	☐	Stroke	☐	☐
Cataracts	☐	☐	Hypertension	☐	☐	Thyroid Disease	☐	☐
Clotting Disorder	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
COPD	☐	☐	Liver Disease	☐	☐			

COMMENTS:

OTHER Major Medical Problems: If you have medical conditions not listed above, please describe below. (Example: Cancer what kind and age of onset, Gallbladder Disease, Colon Polyp, Prostate, Migraines, Skin Conditions, Fibroids, Endometriosis, etc.)

SURGICAL HISTORY: Have you had any of these procedures done? Please check YES on all that apply to you.

Use the comment section below for further details.

Procedure	Y	N	Appx. Date	Procedure	Y	N	Appx. Date	Procedure	Y	N	Appx. Date
Appendectomy	☐	☐	_____	C-Section	☐	☐	_____	Prostate Surgery	☐	☐	
Brain Surgery	☐	☐		Eye Surgery	☐	☐		Small Intestine Surgery	☐	☐	
Breast Surgery	☐	☐		Fracture Surgery	☐	☐		Spine Surgery	☐	☐	
CABG	☐	☐		Hernia Repair	☐	☐		Tubal Ligation	☐	☐	
Cholecystectomy	☐	☐		Hysterectomy	☐	☐		Valve Replacement	☐	☐	
Colon Surgery	☐	☐		Joint Replacement	☐	☐		Vasectomy	☐	☐	
Cosmetic Surgery	☐	☐									

COMMENTS:

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Community Health Centers

Patient's Name:_____ MRN: _____ Date of Birth:_____

BIOLOGICAL FAMILY MEDICAL HISTORY:

Please check the box to show which family member had the condition. Include only blood relatives.

☐ Check here if you do not know medical information about your birth parents and family	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problem
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments				What kind? At what age?	At what age?		Type 1 or 2?				What kind?		

List any other pertinent Family History: _____

_____

BIRTH HISTORY:

Have you ever been pregnant? No ☐ Yes ☐ If yes, # of times: _____ # of live births: _____

# of miscarriages (spontaneous abortion) _____ # of therapeutic abortions _____

# of multiple births _____ # of tubal pregnancy (ectopic pregnancies) _____

Have you ever had an abnormal pap test? If yes, where and when? _____

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Patient's Name:_____ MRN: _____ Date of Birth:_____

HEALTH SCREENING: If you remember when you had any of these tests, please write the date below:

Screening	Appx Date	Where?	Screening	Appx Date	Where?
Pap Smear	_____	_____	Mammogram	_____	_____
Cholesterol/Lipid ~~Test~~	_____	_____	Dental Exam	_____	_____
Colon/Sigmoidoscopy	_____	_____	Bone Density (Dexa)	_____	_____
HIV Test	_____	_____	PSA Test	_____	_____
Eye Exam	_____	_____			

ALLERGIES:

List all medication allergies you have

☐ No medication allergies

_____

_____

_____

List all other allergies you have

☐ No other allergies

_____

_____

_____

MEDICATIONS LIST: List all medications that you take regularly including non-prescription vitamins, herbs & supplements. *If you brought them with you to your appointment, you do not need to complete this section.*

☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

- **I have read a copy of the bisphosphonate alert and understand that a copy can be provided to me upon my request.**
- **I have read the above and have filled out this health history completely, to the best of my ability.**

Signature (of Patient or Party Responsible): _____ Date: _____

Open Door Community Health Dental Centers
Combined Signatures Form – Burre Dental Health Center

Bisphosphonate Alert: I have read a copy of the Bisphosphonate alert. I will notify the dentist if I have ever taken any of these medications.	**Initial:**
Participation in Dental Education / Teaching Programs: The Burre Dental Center is a teaching facility. Patients at the Burre Dental Center may receive treatment by residents, with the approval of the patient's attending dentist in affiliation with University of California, San Francisco and NYULutheran Medical Center and College of the Redwoods dental assisting program. Please be advised that residents/Interns take longer to complete complex procedures. **I have the right to refuse service by a resident or intern. I understand that refusal will also result in extended length of times between appointment(s).**	**Initial:**
Dental Materials Fact Sheet: I have had an opportunity to review the Dental Materials Fact Sheet from the Dental Board of California.	**Initial:**
Emergency Appointment policy and Stand-By Appointment Policy: I have read and fully understand the policy information provided (form 578).	**Initial:**
Missed Appointments Policy: I have read and understand the supplied handout (form 452). I will keep the appointments I schedule, and should I need to cancel or reschedule an appointment, I will provide at least 24 advance notice. I will comply with the terms of the policy as stated.	**Initial:**
Behavior Policy: Ranting, arguing, shouting or threatening are grounds for immediate and permanent dismissal from any or all of the Open Door Community Health Centers. I understand and agree to the terms of this policy.	**Initial:**
Notice of Privacy Practices: I have been offered a copy of ODCHC's Notice of Privacy Practices.	**Initial:**
Welcome to Burre Dental Document: I have read, fully understand and agree to the policies that are explained in the document.	**Initial:**

You may have a copy of any of the above documents on request.

Signature: _____ Date: _____

Patient / Parent: _____ Relationship: _____

Consent to Treatment, Assignment of Benefits & Release of Information

- I am presenting myself for the purpose of obtaining health care from the practitioners associated with the Open Door Community Health Centers.
- I understand that the clinic is not an emergency facility. In cases of life-threatening emergencies, I should go to the hospital emergency room or call 9-1-1.
- I understand that I am financially responsible for the charges related to my medical, dental or hospital diagnosis, treatment or care. I also understand that failure to pay all or part of the charges owed to the clinic may result in collection actions and/or a restriction of future services.
- I have received a copy of the Notice of Privacy Practices of Open Door Community Health Centers. I understand that Open Door Community Health Centers shares certain types of information with other health care providers, public agencies and payors, as a part of our health care operations. I understand that I have the right to request that specific information not be shared, and that I should request more information if I have questions or concerns.
- I certify, under penalty of perjury, that the information provided is true and correct to the best of my knowledge.
- *For patients with insurance:* I authorize payment of medical benefits from my health care insurers to the Open Door Community Health Centers for services rendered. I consent to the release of any medical information necessary to process claims for insurance payment.

Consentimiento para Tratamiento, Asignación de Beneficios & Revelación de Información

- *Yo me presento con el propósito de obtener atención de salud de parte de los practicantes médicos o dentales asociados con Open Door Community Health Centers.*
- *Entiendo que la clínica no es una sala de emergencia. En caso de emergencia de vida o muerte, debo ir a la sala de emergencia del hospital o llamar al 9-1-1.*
- *Entiendo que soy responsable financieramente por los gastos y cargos relacionados con mi diagnóstico, tratamiento y cuidado, bien sea médico, dental u hospital. Entiendo también que no pagar los gastos en total puede resultar en una conbranza jurídica y/o restricción de mis servicios en el futuro.*
- *He recibido La Noticia que describe el uso de información personal medical. Entiendo que Open Door Community Health Centers compartira ciertos tipos de información con otras oficinas médicas, practicantes médicos y pagadores, como un parte normal de nuestros negocios. Entiendo también que tengo el derecho a pedir que no séa compartida cierta información, y que debo pedir más información si estoy preocupado o tengo preguntas.*
- *Doy fe bajo la pena de perjurio que la información es verdadera y corecta según mi leal entender y saber.*
- *Para pacientes con aseguranza: Autorizo el pago de beneficios médicos de mi aseguranza al Open Door Community Health Centers para los servicios recibidos. Autorizo la entrega de mi información médica para procesar esta pretensión.*

Signature/*Firma*: _____ Date/*Fecha*: _____

Printed Name/*Nombre Escrito*: _____

OPEN DOOR COMMUNITY HEALTH CENTERS **INFORMACIÓN DEL PACIENTE**

Apellido: _____ **Primer Nombre:** _____

Número de Seguro Social: _____ **Fecha de nacimiento:** _____

Dirección (para correo): _____ Ciudad: _____ Código Postal: _____

Dirección (de casa): _____ Ciudad: _____ Código Postal: _____

Número de teléfono: _____ ¿Podemos contactarle en casa? ☐ Sí ☐ No

Otro método de contacto ☐ Teléfono de casa ☐ Teléfono móvil ☐ ☐ Correo electrónico _____

Sexo: ☐ Hombre ☐ Mujer **Otros nombres** que ha usado: _____

Su Lenguaje: ☐ Inglés ☐ Español ☐ Hmong ☐ Otro _____
¿Necesita servicios de interpretación? ☐ Sí ☐ No

Origen Étnico: ☐ Hispano ☐ No Hispano

Raza: ☐ Blanco ☐ Asiático ☐ Americano Nativo ☐ Afroamericano ☐ De Islas Pacíficas ☐ Nativo de Alaska ☐ No se sabe

Estatus migratorio: ☐ Inmigrante ☐ Trabajador temporal ☐ Ninguno de esos

Situación de vivienda: ☐ Ahora tengo hogar ☐ Sin Hogar ☐ Riesgo de perder mi hogar
☐ Vivo en un refugio ☐ Vivo con otras personas ☐ Vivo en la calle, campamento, puente ☐ Hogar temporal

¿Es Veterano militar? ☐ Sí ☐ No

Nombre de Empleador: _____ Teléfono: _____

Contactos en caso de emergencia (para el paciente, o para el padre/guardián si el paciente es menor de edad)

Nombre de contacto en caso de emergencia: _____ Teléfono: _____

Relación con el paciente ☐ Esposa/o ☐ Mamá ☐ Papá ☐ Abuelos ☐ Otro _____

Otro método de contacto ☐ Teléfono de casa ☐ Teléfono móvil ☐ ☐ Correo electrónico _____

Número de Medi-Cal: _____ Fecha de emisión: _____

Información del fiador (La persona que paga los cobros, por ejemplo: El padre de un paciente menor de edad.)

Apellido: _____ **Primer Nombre:** _____

Dirección: ☐ La misma descrita arriba _____ Ciudad/Código Postal: _____

Relación al paciente: ☐ Padre ☐ Esposo/a ☐ Otro: _____ **Numero de Seguro Social:** _____

Sexo: ☐ Hombre ☐ Mujer **Fecha de nacimiento**: _____ **Teléfono:** _____

Datos Sobre Ingresos: *Usamos esta información para la escala de descuentos.*

Ingreso de familia: $_____ por: ☐ Año ☐ Mes ☐ Semana # de personas en la familia: _____
☐ Prefiero omitir esa información.

Entered by: _____ **Date:** _____

Información de Vivienda e Ingreso

Programa de descuento de tarifa variable

opendoor Community Health Centers

¿Por qué pedimos esta información?

Los Centros de Salud Comunitarios Open Door reciben subsidios y fondos federales para apoyar nuestros servicios. Cada año debemos recopilar información sobre las comunidades que servimos para compartir con nuestros financiadores. Al completar este formulario, nos está ayudando a mantener nuestros fondos para que podamos ofrecer más servicios.

Combinamos su información con otras y la informamos en forma resumida. No compartimos ninguna información personal ni informamos datos que puedan usarse para identificarlo.

---

1. Información sobre usted y dónde vive

Nombre	**Fecha de nacimiento**	**Uso de MRN** Office

¿Es usted un veterano? (Marque uno) ☐Sí ☐No

¿Cómo describe el lugar dónde vive? (Marque uno)

- ☐ Vive en su propia casa o renta (casa, apartamento o condominio)
- ☐ Vive con otra persona de forma temporal ("por ejemplo, durmiendo en el sofá en la casa de otra persona")
- ☐ Vive en una vivienda de transición (Casa Arcata u otra casa de transición)
- ☐ Vive en algún lugar como parte de un programa o tratamiento (hospital, hotel o motel, cuidado de relevo, programa de tratamiento, cárcel)
- ☐ Vive en un refugio de emergencia
- ☐ Vive desprotegido (en una tienda de campaña, automóvil, alrededor de edificios o puentes)

¿En algún momento de los últimos 12 meses estaba sin un lugar regular para vivir?
(Marque uno) ☐Sí ☐No

2. Información sobre las personas en su hogar

Por favor, enumere los nombres y fechas de nacimiento de las personas en su hogar. Su hogar incluye a las personas con las que vive y con las que comparte un ingreso.

Nombre	**Fecha de nacimiento**	**Uso de MRN** Office

3. Información sobre los ingresos del hogar

¿Cuál es el ingreso de su hogar antes de impuestos o deducciones? Esta es la cantidad total ganada por todos los miembros de su hogar, incluyéndolo a usted.

Ejemplos de ingresos (marque todos los que correspondan):

- ☐ Salarios o salarios del empleo o del trabajo por cuenta propia
- ☐ Otras ganancias del empleo, como propinas o comisiones
- ☐ Manutención de los hijos
- ☐ Manutención conyugal
- ☐ Cualquier otra fuente de ingreso_____
- ☐ Pensión alimenticia
- ☐ Pensión o ingresos de jubilación
- ☐ Seguridad social
- ☐ Pagos por discapacidad
- ☐ Pagos por desempleo

Ingreso total del hogar: $_____

¿Es este ingreso? (Cheque uno) ☐ Semanal ☐ Mensual ☐ Anual

4. Elegibilidad para el copago de la escala de descuento de tarifas proporcionales

Según los ingresos de su hogar informados anteriormente, puede ser elegible para un descuento en las tarifas de sus servicios.

Si no reporta ningún ingreso arriba, debe describir su medio actual de manutención y / o situación de vida:

_____

Nos reservamos el derecho de solicitar evidencia de sus ingresos en forma de talones de pago, declaraciones de impuestos u otros documentos para calificar para descuentos.

5. Certificación y firma

Declaro que la información que he dado en este formulario es verdadera, correcta y completa. Entiendo que la entrega de información falsa puede hacerme inelegible para servicios con descuento.

Firma_____ Fecha: _____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount ☐ Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

Consent to Treatment, Assignment of Benefits & Release of Information

- I am presenting myself for the purpose of obtaining health care (medical, dental, telehealth) from the practitioners associated with the Open Door Community Health Centers.
- I understand that the clinic is not an emergency facility. In cases of life-threatening emergencies, I should go to the hospital emergency room or call 9-1-1.
- I understand that I am financially responsible for the charges related to my medical, dental or hospital diagnosis, treatment or care. I also understand that failure to pay all or part of the charges owed to the clinic may result in collection actions and/or a restriction of future services.
- I have received a copy of the Notice of Privacy Practices of Open Door Community Health Centers. I understand that Open Door Community Health Centers shares certain types of information with other health care providers, public agencies and payors, as a part of our health care operations. I understand that I have the right to request that specific information not be shared, and that I should request more information if I have questions or concerns.
- I certify, under penalty of perjury, that the information provided is true and correct to the best of my knowledge.
- *For patients with insurance:* I authorize payment of medical benefits from my health care insurers to the Open Door Community Health Centers for services rendered. I consent to the release of any medical information necessary to process claims for insurance payment.

Consentimiento para Tratamiento, Asignación de Beneficios & Revelación de Información

- Yo me presento con el propósito de obtener atención de salud (médica, dental, telesalud) de parte de los practicantes médicos o dentales asociados con Open Door Community Health Centers.
- Entiendo que la clínica no es una sala de emergencia. En caso de emergencia de vida o muerte, debo ir a la sala de emergencia del hospital o llamar al 9-1-1.
- Entiendo que soy responsable financieramente por los gastos y cargos relacionados con mi diagnóstico, tratamiento y cuidado, bien sea médico, dental u hospital. Entiendo también que no pagar los gastos en total puede resultar en una conbranza jurídica y/o restricción de mis servicios en el futuro.
- He recibido La Noticia que describe el uso de información personal medical. Entiendo que Open Door Community Health Centers compartira ciertos tipos de información con otras oficinas médicas, practicantes médicos y pagadores, como un parte normal de nuestros negocios. Entiendo también que tengo el derecho a pedir que no séa compartida cierta información, y que debo pedir más información si estoy preocupado o tengo preguntas.
- Doy fe bajo la pena de perjurio que la información es verdadera y corecta según mi leal entender y saber.
- Para pacientes con aseguranza: Autorizo el pago de beneficios médicos de mi aseguranza al Open Door Community Health Centers para los servicios recibidos. Autorizo la entrega de mi información médica para procesar esta pretensión.

Signature/*Firma*: _____ Date/*Fecha*: _____

Printed Name/*Nombre Escrito*: _____

MR# _____

Open Door Community Health Dental Centers
Combined Signatures Form – Burre Dental Health Center

Bisphosphonate Alert: Yo he leido la información sobre **bifosfonato**. Yo notificaré el dentista si yo he tomado alguno de esas medicinas.	**Iniciales:**
Participation in Dental Education / Teaching Programs: La clínica Burre Dental Center participa en un programa de enseñanza dental. Clientes del Burre Dental Center podria recibir tratamientos por estudiantes en esa programa, con la aprobación y supervision del dentista. Los estudiantes son afiliados con la Universidad de California-San Francisco, Lutheran Medical Center, y College of the Redwoods programa por Ayudantes Dentales. **Tengo el derecho de rechazar servicios dentales por un residente o alumno interno. Entiendo que esto puede extender el tiempo necesario para completer mis citas.**	**Iniciales:**
Dental Materials Fact Sheet: Yo he tenido la oportunidad de leer la Hoja Informativa Sobre Materiales Dentales, proveido por el Dental Board of California.	**Iniciales:**
Emergency Appointment policy and Stand-By Appointment Policy: Yo he leido y entendido la información sobre Citas de Emergencia y Citas en Reserva Activa (form 578S).	**Iniciales:**
Missed Appointments Policy: Yo he leido y entendido la informacion sobre citas falladas (form 452). Yo mantendré mis citas. Si necesito cancelar o cambiar una cita, yo notificaré la clínica 24 horas o más antes de mi cita. Yo me conformaré con la policia representada.	**Iniciales:**
Behavior Policy: Gritando, discutando, usando palabrotas o amenazando son totalmente prohibidos y son motivos por despido inmediatamente y permanente de los Open Door Community Health Centers. Yo entiendo y acuerdo con esa policia.	**Iniciales:**
Notice of Privacy Practices: Tengo la oportunidad de leer y recibir una copia del Aviso Sobre Las Practicas de Privadica de ODCHC.	**Iniciales:**
Bienvenido a Burre Dental document: Eh leido, y estoy de acuerdo con las polisa que se explican en el documento.	**Iniciales:**

Entiendo que puedo pedir una copia de alguno de la policies citadas arriba.

Firma: _____ Fecha: _____

Pariente/Guardián: _____ Relación: _____

OPEN DOOR COMMUNITY HEALTH CENTERS
HISTORIAL DEL PACIENTE

Nombre del Paciente:_____ MRN: _____ Fecha de Nacimiento:_____

HISTORIA MÉDICA: ¿Ha tenido cualquiera de estas condiciones? Marque SÍ en todas las condiciones que apliquen para usted. Use la sección de comentarios a continuación para obtener una explicación más detallada

Condición	S	N	Condición	S	N	Condición	S	N
Abuso como Adulto	☐	☐	Depresión	☐	☐	Meningitis	☐	☐
Abuso Infantil	☐	☐	Diabetes	☐	☐	Trastorno de salud mental	☐	☐
ADD/ADHD	☐	☐	Drogadicción	☐	☐	Historia de la infección SARM	☐	☐
Alcoholismo	☐	☐	Enfisema/EPOC	☐	☐	Lesión al Miocardio	☐	☐
Alergias	☐	☐	Glaucoma	☐	☐	Enf. Nerviosa/Muscular	☐	☐
Anemia	☐	☐	Enfermedad del Corazón	☐	☐	Osteoporosis	☐	☐
Ansiedad	☐	☐	Insuficiencia Cardiaca	☐	☐	Marcapasos	☐	☐
Artritis	☐	☐	Soplo Cardiaco	☐	☐	Convulsiones	☐	☐
Asma	☐	☐	Endocarditis del corazón	☐	☐	Anemia Falciforme	☐	☐
Autismo	☐	☐	Historia de la transfusión de sangre	☐	☐	Enf. de Transmisión Sexual	☐	☐
Fractura de mandíbula	☐	☐	VIH/SIDA	☐	☐	Ulcera Estomacal	☐	☐
Cáncer	☐	☐	Hiperlipidemia	☐	☐	Derrame Cerebral	☐	☐
Cataratas	☐	☐	Hipertensión	☐	☐	Enfermedad de Tiroides	☐	☐
Trastorno de Coagulación	☐	☐	Enfermedad del Riñón	☐	☐	Tuberculosis	☐	☐
EPOC (COPD in ingles)	☐	☐	Enfermedad del Hígado	☐	☐			

COMENTARIOS:

_____

_____

OTROS Mayores Problemas Médicos: Si tiene condiciones médicas no mencionadas anteriormente, describa abajo. (Por ejemplo: Cáncer de cualquier tipo y edad de inicio, Enfermedad de la Vesícula, pólipo de colon, próstata, migrañas, afecciones de la piel, fibromas, endometriosis, etc.)

_____

_____

CIRUGIAS: ¿Ha realizado alguno de estos procedimientos? Por favor marque SÍ en todo lo que aplique para usted. Use la sección de comentarios abajo para más detalles

Procedimiento	S	N	Fecha Aprx.	Procedimiento	S	N	Fecha Aprx.	Procedimiento	S	N	Fecha Aprx.
Apendectomía	☐	☐	_____	Cesárea	☐	☐	_____	Cirugía de Próstata	☐	☐	_____
Cirugía cerebral	☐	☐	_____	Cirugía de Ojo	☐	☐	_____	Cirugía de Intestino Delgado	☐	☐	_____
Cirugía Mamaria	☐	☐	_____	Cirugía de Fractura	☐	☐	_____	Cirugía de Columna	☐	☐	_____
CABG	☐	☐	_____	Reparación de Hernia	☐	☐	_____	Ligadura de Trompas	☐	☐	_____
Colecistectomía	☐	☐	_____	Histerectomía	☐	☐	_____	Reemplazo de Válvula	☐	☐	_____
Cirugía de Colon	☐	☐	_____	Reemplazo de Articulación	☐	☐	_____	Vasectomía	☐	☐	_____
Cirugía Cosmética	☐	☐	_____								

COMENTARIOS:

_____

_____

opendoor Community Health Centers

Nombre del Paciente:_____ MRN: _____ Fecha de Nacimiento:_____

HISTORIAL DE FAMILIA:

Por favor marque la caja para indicar cual miembro de su familia tuvo la condición, solo incluye parientes biológicos

☐ Marque aquí si no conoce información médica sobre sus padres biológicos y familiares	Abuso de Alcohol / Droga	Artritis	Asma	Cáncer	Problemas de Corazón	Depresión	Diabetes	Colesterol Alto	Hipertensión	Enfermedad de Riñón	Enfermedad Mental	Derrame Cerebral	Problemas de Visión
Madre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Padre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hermana	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hermano	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hija	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hijo	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tía de mi Madre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tío de mi Madre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tía de mi Padre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tío de mi Padre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Madre de mi Madre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Padre de mi Madre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Madre de mi Padre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Padre de mi Padre	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comentarios:				¿Qué tipo? ¿A qué edad?	¿A qué edad?		Tipo 1 o 2?				¿Qué tipo?		

Liste cualquier otra historia familiar pertinente_____

HISTORIAS DE NACIMIENTOS:

¿Alguna vez ha estado embarazada? No ☐ Si ☐ En caso de si, # de veces _____

de nacimientos vivos: _____ # de abortos espontáneos (spontaneous abortion) _____

de abortos terapéuticos _____ # de patos múltiples _____

de embarazo ectópico (ectopic pregnancies) _____

¿Alguna vez le hicieron una prueba de Papanicolaou con resultado anormal? _____

En caso de si, ¿dónde y cuándo? _____

opendoor Community Health Centers

Nombre del Paciente:_____ MRN: _____ Fecha de Nacimiento:_____

EXAMENS DE SALUD: Si recuerda cuándo tuvo alguna de estas pruebas, escriba la fecha abajo:

Examen	Fecha Aprx	¿Donde?	Examen	Fecha Aprx	¿Donde?
Papanicolaou	_____	_____	Mamografía	_____	_____
Examen de Colesterol	_____	_____	Examen Dental	_____	_____
Colon/Sigmoidoscopia	_____	_____	Examen de Densidad Ósea	_____	_____
Examen de VIH	_____	_____	Examen de PSA (Próstata)	_____	_____
Examen Ocular	_____	_____			

ALERGIAS:

Haga una lista de todas las alergias que tenga a los medicamentos

☐No tengo alergias a los medicamentos

_____

_____

_____

Haga una lista de otras alergias que tenga

☐No tengo otras alergias

_____

_____

_____

LISTA DE MEDICACION: Haga una lista de todos los medicamentos que toma regularmente, incluya las vitaminas, hierbas y suplementos sin receta. *Si trajo sus medicinas a su cita, no es necesario que complete esta sección.*

☐Ninguno/a

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

¿Hay algún otro medicamento que otro proveedor de salud le ha recetado? Escriba aqui:

_____

_____

- **He leído la alerta acerca de los bisfosfonatos**
- **He leído lo de arriba y he contestado este cuestionario a mi mejor habilidad**

Firma (de Paciente o Persona Responsable): _____ Date: _____

HUMBOLDT COUNTY

FREE Healthcare Clinic

Adorni Center

1011 Waterfront Drive ~ Eureka, CA

July 12-13, 2024

7:00 am - 5:00 pm daily (as capacity allows)

www.californiacareforce.org

California CCF Volunteers CareForce™

MEDICAL

- General exams
- Blood pressure & blood glucose screening
- Other services as available

VISION

- Vision exams
- Eye health checks
- Free prescription glasses made on-site

DENTAL

- X-rays
- Cleanings
- Fillings
- Extractions

INFO

- FREE services -- we do NOT ask for documentation, immigration status, or proof of insurance, employment, income, residency, or ID
- First come, first serve basis as capacity allows (gate opens daily at 5:30 AM)
- Bring: prescription meds, food & water
- DO NOT BRING: illegal drugs, alcohol or weapons

More Info? Call 916-749-4170

HUMBOLDT LIBRARY
COUNTY OF HUMBOLDT
1313 THIRD STREET EUREKA, CALIFORNIA 95501
PHONE (707) 269-1900

May 21, 2024

Dear Administrators, Faculty, and Staff,

The Humboldt County Library is once again offering a summer reading challenge for children, teens, and adults. Please share with your school community the attached flyer which provides information about this year's summer challenge. You, your students, and their families are invited to join in summer fun!

This year's theme is **Read, Renew, Repeat** – a nod to conservation and a reminder to all of us to care for ourselves, for one another, and for the planet. We have many wonderful print and electronic reading materials to inspire and engage readers of all ages and reading levels on these important themes – and our librarians are delighted to make recommendations!

To participate, just sign up and get a reading log at any Humboldt County Library branch (or the bookmobile). Readers can set their own daily reading goals for the summer; this could be 100 pages for fluent readers or a few independent minutes for emergent readers. Listening to audiobooks or books read aloud counts, too! They can then submit up to three completed logs to be entered into a drawing for prizes generously donated by partner organizations in the community. We believe this personalized reading goal makes the challenge both accessible and rewarding for students with a range of interests and abilities.

We all know how important it is to keep minds and bodies active during the summer months and to continue developing literacy skills and a lifelong love of reading. The library's summer reading program is a free, easy, and fun way for parents and teachers to encourage youth to develop and strengthen their reading fluency, comprehension and agency.

Sign-ups are happening now! The challenge will run from **June 1 to August 17**. Visit our website to learn more and our events calendar to see our growing list of summer activities. I hope that you will encourage the children and families you serve to make the Humboldt County Library reading challenge a part of their summer plans.

Sincerely,

Ryan Keller
Youth Services Librarian Support
(707)269-1921
rkeller2@co.humboldt.ca.us

SUMMER READING PROGRAM

THURSDAY CRAFTY CLUB

HUMBOLDT COUNTY Library

Kids! Come enjoy self-directed craft projects Thursdays 3-4 p.m. in the Children's Room during Summer Reading Program June 1 - August 17!

June 6: Ocean & Animal Collage

June 13: Recycled Bookmarks

June 20: Summer Solstice Paper Plate Sun Project

June 27: Paper Fans & Paper Airplanes

July 11: Recycled Bookmarks & Making Mini Books

July 18: Planting Seeds & Painting Coffee Filter Butterflies

July 25: DIY Musical Instrument Making (for Uncommon Musical Instrument Day)

August 1: Fairy & Elf Houses with Upcycled Materials

August 8: Cat Crafts for International Cat Day

August 15: Micro Kinetic Sculptures with Upcycled Treasures

EUREKA MAIN LIBRARY

1313 Third St, Eureka

(707) 269-1910

SUMMER READING AT YOUR LIBRARY!

Read, Renew, Repeat

IT'S TIME FOR SUMMER READING!

June 1 to August 17

Win Prizes for Reading

Special Events & Activities

All ages are welcome!

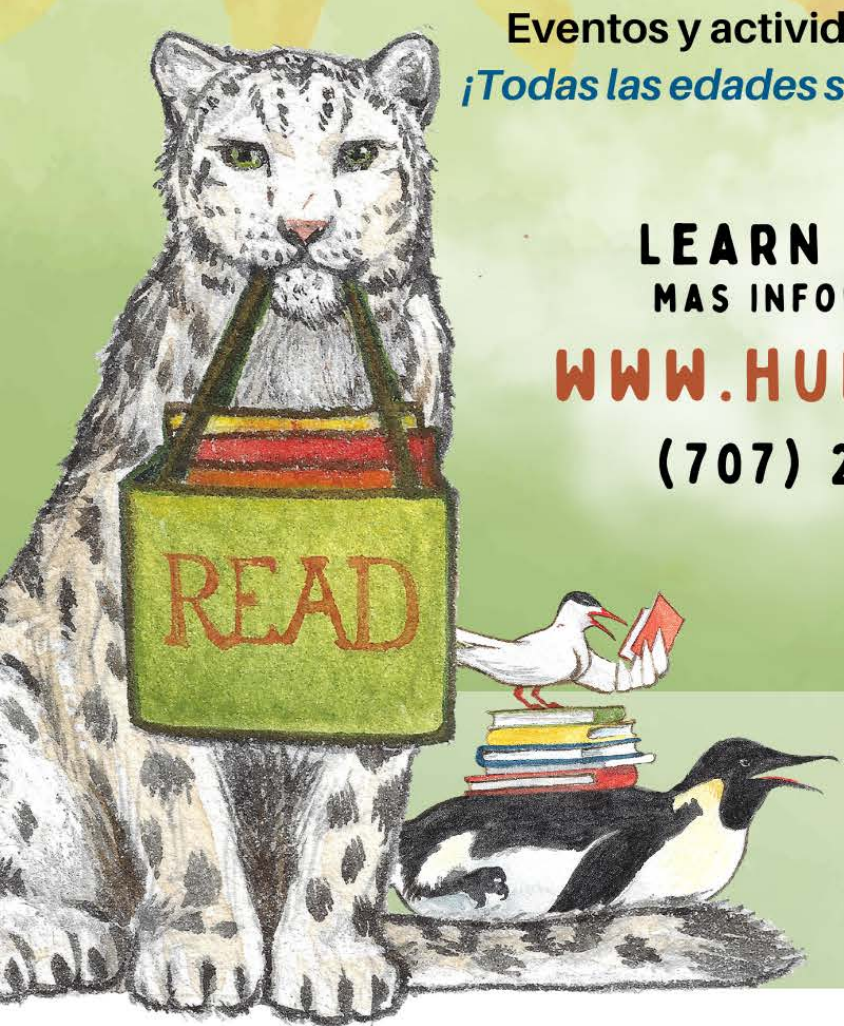
¡ES HORA DE LEER EN EL VERANO!

1 de junio - 17 de agosto

Gana premios por leer

Eventos y actividades especiales

¡Todas las edades son bienvenidos!

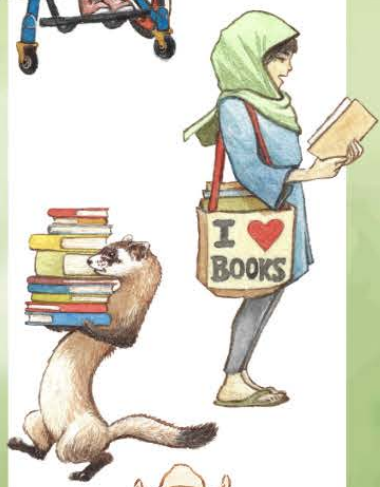


LEARN MORE AT

MAS INFORMACIÓN EN

WWW.HUMLIB.ORG

(707) 269-1910



HUMBOLDT COUNTY Library

First 5 HUMBOLDT

Humboldt Literacy Project

Humboldt Area Foundation

friends of the Redwood Libraries

Sequoia Park Zoo

Los Bagels

Humboldt Sponsors

Humboldt Library Foundation — Open the World

IT'S TIME FOR SUMMER READING!

¡ES HORA DE LEER EN EL VERANO!

SUMMER READING 2024!

HUMBOLDT COUNTY
Library

June 1 to August 17
Win Prizes for Reading
Special Events & Activities
All ages are welcome!

1 de junio - 17 de agosto
Gana premios por leer
Eventos y actividades especiales
¡Todas las edades son bienvenidos!

LEARN MORE AT
MAS INFORMACIÓN EN
WWW.HUMLIB.ORG
(707) 269-1910

HUMBOLDT COUNTY
Library

design
construct
create

LEGO® CLUB Kids!

MAY
Sat, May 11, 2-3:30pm
Wed, May 15, 5-7pm

JUNE
Sat, June 8, 2-3:30pm
Wed, June 26, 5-7pm

Activate your Creativity & Imagination!

Come build cool things with Library LEGO's (leave yours at home please) and show them off in our display case!

Come get creative!

Real Legos for ages 5 and up.
Duplos & Megablox for all ages!

Eureka Library
Children's Room
1313 Third Street, Eureka
(707) 269-1910
www.humlib.org

Mattole River Camp

BETTY KWAN CHINN HOMELESS FOUNDATON

A seasonal camping experience for children, ages 7-14, on the Gregori Family Farm.

- ☑ **Camping equipment provided**
- ☑ **3 meals, 2 large snacks, and water bottles provided daily**
- ☑ **All river gear, arts & crafts supplies, hats & flashlights, and instruments will be provided.**
- ☑ **All river gear, art & craft supplies, hats & flashlights, and instruments will be provided.**

Activities:

-River Fun
-Art Projects
-Music Lessons
-Outside games
-One Day with Local Nature educators
-One Night of story telling by one of Humboldt's renowned story tellers
-Harvesting food and flowers
-Basketball & Ping Pong in the Barn

Campers should bring:

-Sleeping Bags
-Pillows
-Bathing suits
-Night Clothes
-Summer Clothes
-Jackets
-Excitement for lots of coming fun !

June 17th - 21st, 2024

On the Mattole River, in Humboldt County, California

SIGN UP AND REGISTER NOW AT BETTY'S DAY CENTER!

BREAKDANCING
WITH RECKLESS REX

A FREE event for kids, teens, and the adults who love them. Each attendee gets to choose a free book to keep!

Family Literacy Party Library Tour!

Saturday, June 22
Azalea Hall at 2:30 p.m.
1620 Pickett Rd, McKinleyville

Saturday, June 29
Trinidad Town Hall at 1:00 p.m.
409 Trinity St, Trinidad

Explore Breakdancing and Hip-Hop culture with Humboldt Rockers' Reckless Rex. Learn about the history of breaking, see it in action, and learn some moves!

Info: www.humlib.org
(707) 269-1910

Since 1981, Humboldt Literacy Project has provided free, confidential English Language tutoring with programs for native English speakers, English as a second language, and family literacy. Info at (707) 445-3855

Humboldt Literacy Project

Humboldt County Library

Testing

Californians in need of COVID-19 testing can purchase over the counter (OTC) tests at local stores or pharmacies or order through their health insurers or the federal government at special.usps.com/testkits.

Individuals who use OTC tests and do not have a health care provider may access test-to-treat services by contacting Sesame Telehealth at sesamecare.com/covidca or by calling 1-833-686-5051.

COVID-19 Vaccine Resource List

1. *Vaccine Info*

Get vaccinated—it's safe, effective, and free

Appointments are available for all residents age 5 and up through the state's My Turn system. Schedule an appointment at myturn.ca.gov or call 1-833-422-4255.

For step-by-step directions on scheduling a vaccination appointment, click here for English and here for Spanish.

If you have questions or need assistance navigating this process, call Public Health at 1-707-445-6201.

Many local pharmacies are offering COVID-19 vaccine in partnership with the county and federal government. Most pharmacies allow walk-ins, but please call ahead to confirm. Go to vaccines.gov or text your ZIP code to 438829 to check availability at participating pharmacies, or click on the individual links below.

SAFEWAY RITE AID COSTCO PHARMACY Walgreens

CVS pharmacy Walmart

Additional Doses

Additional doses of the mRNA COVID-19 vaccines are available for those who are immunocompromised 28 days after they complete the initial series. An additional dose of the Pfizer or Moderna vaccine is recommended for immunocompromised individuals to achieve maximum protection from the vaccine series. People are encouraged to talk to their health care provider about whether an additional dose is appropriate for them. For more information about additional doses of COVID-19 vaccine, go to cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/immuno.html.

Boosters

Residents who completed a two-dose series of the Pfizer-BioNTech or Moderna COVID-19 vaccine at least 5 months ago are encouraged to get a booster dose.

Residents who received the Johnson & Johnson COVID-19 vaccine at least two months ago are encouraged to get a booster dose.

Residents may choose to receive any authorized or approved vaccine as their booster dose.

For more information about COVID-19 vaccine boosters, go to cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html.

Del Norte Covid-19 Testing

Get Vaccinated!

COVID-19 vaccines are one of the most important tools to end the COVID-19 pandemic. A safe, effective, no-cost vaccine is available to everyone in Del Norte County. Getting vaccinated can help prevent you from getting seriously ill from the virus and protect those around you as well.

Vaccine Locations

Del Norte Public Health
1st and 3rd Tuesday of every month
9:00 am - 11:30 am and 1:30 pm - 3:30 pm.
Appointments Required

Local Pharmacies Offering Vaccines
CVS Pharmacy (Moderna) Walk-in subject to availability.
https://www.cvs.com/immunizations/covid-19-vaccine
Rite Aid Pharmacy (Moderna) Via Appointment
https://www.riteaid.com/covid-19
Safeway Pharmacy (Moderna) Via Appointment on Wednesdays only
https://www.safeway.com/vaccinations/home
Walgreens Pharmacy (Pfizer, Moderna, Janssen) Walk-ins subject to availability.
https://www.walgreens.com/findcare/vaccination/covid-19/location-screening
1-800-WALGREENS (1-800-925-4733)
Walmart Pharmacy (Moderna) Walk-ins during pharmacy hours.
https://www.walmart.com/cp/immunizations-flu-shots/1228302

Talk to your Primary Health Provider.
Many healthcare offices offer Covid-19 vaccinations. Talk to your Doctor.

Get Tested.

We recommend getting tested as soon as possible if you are experiencing COVID-19 symptoms, even if you are vaccinated.
You should also get tested if:

- You have been in close contact with someone who has COVID-19
- You have taken part in activities that put you at higher risk for COVID-19, such as travel, attending large gatherings, or being in crowded indoor settings
- Your employer requires routine screening

Free Rapid Tests

A limited amount of free rapid tests are available through Public Health. Please call to check availability at 707-464-0861.
They can be picked up at:
400 L Street
Crescent City, CA 95531

Del Norte

Community Transmission Level

Low

Masking is Strongly Recommended

Transmisión Comunitaria

Baja

Se Recomienda Mascarilla

Humboldt

Community Transmission Level

Low

Masking is Strongly Recommended

Transmisión Comunitaria

Baja

Se Recomienda Mascarilla