EASTERN NEW MEXICO UNIVERSITY ROSWELL

Special Services Program

Dear Interested Student for the 2021-2022 Academic Year:

On behalf of the Special Services Program at ENMU-Roswell, we appreciate your interest and look forward to helping you with the application process. Special Services is one of just a few university programs in the nation offering Certificates of Training in a vocational field, along with core subjects that advance skills in independent living. We offer certificate programs designed for students with disabilities, who with appropriate training are able to obtain positions in competitive employment.

On the next page is a checklist that will guide you through the process of applying to the Special Service Program. We will be accepting applications for Fall 2021 enrollment until May 1, 2021. We encourage you to apply as soon as possible as classes can fill up quickly.

Program information is available in the ENMU-R Catalog which is accessible at: www.roswell.enmu.edu. You may also contact our Special Services Coordinator, Brianna Bitner, at brianna.bitner@roswell.enmu.edu, with any questions.

Once again, thank you for your interest and we look forward to receiving your completed application. Please call our office at 575-624-7286 with any questions or concerns, or if you would like additional information.

Sincerely,

Rebecca L. Cobos, MSW
Director of Special Services

Revised: 08/18/2020

Checklist for a Complete Application Packet

Please initial next to each item as complete

_____ 1. This checklist with initials
_____ 2. Application for ENMU Roswell Special Services
_____ 3. Entrance Requirements
_____ 4. ENMU Roswell Application for Undergraduate Admissions
_____ 5. ENMU Roswell Information Release (must be notarized-mail original)
_____ 6. Guardianship and/or Power of Attorney Forms (if applicable)
_____ 7. Requested copy of high school transcripts be mailed to ENMU Roswell Special Services
_____ 8. Sierra Vista Village Housing Application
_____ 9. Special Services Medical Statement
_____ 10. ENMU Roswell Health Registration, Consent to Treat, and Release of Information
_____ 11. La Casa Health Center Forms
_____ 12. Copy of Medical Insurance Card(s)
_____ 13. DSM 5 Self Rated Form
_____ 14. Support Documentation of a Disability (failure to provide full disclosure could lead to dismissal of acceptance and/or removal from the program)
    _____ a. Individualized Education Plan – Most Recent
    _____ b. Educational Diagnostic Evaluations – Most Recent
    _____ c. Vocational Evaluation/Assessment – Not Required, but Please Submit if one is Available
    _____ d. Medical Documentation for Known Conditions (e.g. epilepsy, diabetes, cerebral palsy, etc.)
    _____ e. Psychiatric/Psychological Documentation for Known Conditions (e.g. ADHD, depression, anxiety, bipolar disorder, schizophrenia, etc.)

Mail Completed Application Packet to:

ENMU Roswell

Special Services (282)

PO Box 6000

Roswell, NM 88202

Applications will be accepted until May 1, 2021. We strongly encourage you to apply early as classes fill up quickly.

Application for Eastern New Mexico University Roswell Special Services Program

2021-2022 Academic Year

Applicant Name: _____
First Name **Middle Name** **Last Name**

Applicant Date of Birth: _____

Applicant Mailing Address: _____

_____

Applicant Cell Phone: _____

Applicant Email Address: _____

Choose from two vocational options: Animal Healthcare, Child Care Attendant, Food Service, Office Skills, and Stocking & Merchandising

First Vocational Choice: _____

Second Vocational Choice: _____

Parent/Guardian: _____

Mailing Address: _____

_____

Cell Phone: _____

Email Address: _____

Parent/Guardian: _____

Mailing Address: _____

_____

Cell Phone: _____

Email Address: _____

Does parent have legal guardianship of applicant? YES / NO

Does parent have Power of Attorney of applicant? YES / NO

If there is legal guardianship or Power of Attorney, copies of these documents must be submitted with application packet.

_____ _____ _____

Student Signature/Date **Parent/Guardian Signature/Date** **Parent/Guardian Signature/Date**

Entrance Requirements

Special Services Occupational Training Program

The following criteria and/or documentation will be used to help determine acceptance into the program:

1. Most recent Individualized Education Plan and educational diagnostic report from high school. Candidates are also encouraged to submit a professional vocational assessment showing the student's abilities and skills in relation to the specific vocation of interest.
2. Complete documentation and full disclosure of medical/psychological/developmental disabilities. *Failure to provide full disclosure could lead to dismissal of acceptance and/or removal from the program.*
3. Minimum 18 years of age.
4. Self-medicate with no assistance. The ability to follow directions from nurses, doctors, or pharmacy and manage medical and psychological issues appropriately and to take the appropriate medicine at the right time.
5. Independently awaken to an alarm. Attend classes and practicum regularly and on time.
6. Be able to utilize public transportation independently.
7. Maintain appropriate personal hygiene, dorm room, and laundry.
8. Demonstrate effective communication skills including the ability to read, write, process information, follow instructions from faculty and staff, and respond appropriately. Demonstrate appropriate social behavior, including the ability to get along with peers and follow rules.
9. Meet minimum entrance requirements for the selected study discipline.
10. Current proof of negative tuberculosis (TB) testing and Tetanus, Diphtheria, and Pertussis (TDaP) immunization required if going into Child Care Attendant Program.
11. Student interview in person, by video chat, or phone.

A committee is utilized to determine admission into the Special Services Occupational Training Program and reviews all applications.

Applicant and Parent/Guardian Signature Below:

"We understand the above entrance requirements"

Applicant Signature	**Applicant Printed Name**	**Date**
Parent/Guardian Signature	**Parent/Guardian Printed Name**	**Date**

Application for Undergraduate Admission

Personal Information

Please complete in black ink

Legal name
Last name | First name | Middle initial

Previous or other legal names
Name

Legal mailing address
Mailing address street and number or PO box number | Apartment, Room or Space No.
City | State | ZIP
Physical mailing address (if different from mailing address)

Phone
☐☐☐-☐☐☐-☐☐☐☐ Home ☐☐☐-☐☐☐-☐☐☐☐ Cell-Work

E-mail
E-mail

Date of birth
☐☐-☐☐-☐☐☐☐
Month Day Year

Place of birth
City/State/Country

Gender ☐ Male ☐ Female

Social security number ☐☐☐-☐☐-☐☐☐☐ (Your SSN is used to ensure an accurate academic record and will not be used as your primary ID. If you are unable to provide an SSN, the University will assign an alternate number to you. This will not impact the admission decision.)

Family history
Did either of your parents or guardians graduate from a community college or university? ☐ Yes ☐ No

Race/Ethnicity
This information is requested by government agencies to demonstrate compliance with the Civil Rights Act. The information will not be used in a discriminatory manner. Your response is voluntary.

Please indicate whether you consider yourself to be Hispanic/Latino: ☐ Yes ☐ No

In addition, select one or more of the following racial categories to describe yourself:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Residency
What is your legal state of residence? _____

How long have you been living continuously in New Mexico? _____ Years _____ Months _____ Days

Citizenship
Please attach a copy of your residency card, front and back, to this application.

Are you a U.S. citizen? ☐ Yes ☐ No
If no, country where you hold citizenship: _____
If alien resident, please provide your resident alien number: A# ☐☐☐-☐☐☐-☐☐☐

Military service
Please contact the admissions office for Military Waiver Form.

Are you active duty military/national guard/reserves? ☐ Yes ☐ No Is your spouse active duty military? ☐ Yes ☐ No
Are either of your parents active duty military? ☐ Yes ☐ No
If yes, are you or your parents stationed in New Mexico? ☐ Yes ☐ No

Self-Disclosure
Required for Admission

Have you ever been dismissed, suspended or restricted from entering a campus from any college or university for academic or disciplinary reasons? ☐ Yes ☐ No

Have you ever been charged with, convicted of or pled guilty to a felony offense in any court, including deferred adjudication?* ☐ Yes ☐ No

* If yes, you must attach a detailed explanation. Include state and location, dates and case number. If applicable, provide the name and phone number of a probation officer. You are under a continuing obligation to immediately update your response to this question if your circumstances change after you submit this application.

Financial aid
Degree-seeking students only.

Are you planning to apply for financial aid or student loans? ☐ Yes ☐ No

Enrollment Information

Campus where you plan to enroll ☐ Portales ☐ Ruidoso ☐ Roswell

Semester you plan to start ☐ Fall ☐ Spring ☐ Summer Year ☐☐☐☐

Your enrollment status
Does not include college courses taken prior to high/home school graduation or GED completion.

- ☐ First enrollment in **any** college or university after high school graduation
- ☐ Transfering to ENMU from a college or university **outside New Mexico**
- ☐ Transfering to ENMU from a college or university **in New Mexico**
- ☐ Readmission—returning after absence from ENMU location:
  ☐ Portales ☐ Roswell ☐ Ruidoso Year(s) _____
- ☐ Previously applied for admission but did not attend ENMU:
  ☐ Portales ☐ Roswell ☐ Ruidoso Year(s) _____

Intended degree
*Nondegree not eligible for financial aid.

- ☐ Certificate
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Second bachelor's degree
- ☐ *Nondegree: updating job skills
- ☐ *Nondegree: updating personal skills

Field of study

Academic major: _____

Other areas of interest: _____

Academic Information

High school last attended

Name _____ City _____ State _____

Did you take college courses while in high school? ☐ Yes ☐ No

High school graduation

High school diploma? ☐ Yes ☐ No Graduation date: ☐☐/☐☐☐☐ (Month/Year)

Home school diploma? ☐ Yes ☐ No

or GED completion

GED certificate? ☐ Yes ☐ No Certificate date: ☐☐/☐☐☐☐ (Month/Year)

State tested: _____ Last grade attended: _____

Previous colleges or universities attended

Beginning with the current or most recent, list all colleges, universities and technical/vocational schools previously attended.

Academic regulations require that students who have registered at other colleges or universities may not disregard their records at such institutions when making application for admission to this University.

Failure to report all institutions attended and not submitting a transcript may result in delay of admission, loss of credit or dismissal from the University.

Note: You must include colleges you have attended while in high school.	State	From	To	Hours

Required

I affirm the information I have provided on this application form and all other admission material is complete, accurate and true.

I agree to submit other materials required for this admission application and understand that failure to do so, and/or the furnishing of false, incomplete or misleading information in connection with my admission or attendance at Eastern New Mexico University, may result in the termination of my admission and registration at ENMU.

I agree, as a student, I am subject to ENMU policies and procedures.

I understand that directory information as defined by the Family Educational Rights and Privacy Act (FERPA) may be made available to the general public. Directory information is generally not considered harmful to the individual or an invasion of privacy. Items may include name, address, telephone number, e-mail address, major field of study, dates of attendance, enrollment status, degrees and awards received, date and place of birth, most recent previous school attended, photographs, participation in officially recognized activities and sports, height and weight of athletes. I hereby give Eastern New Mexico University permission to use my image (still photograph or video) and name for all nonprofit purposes, such as promoting the University in videos, CD-ROMs, electronic and printed publications, without compensation.

I understand if I want to restrict any or all of the above information, I must notify the Office of the Registrar in writing. I understand these restrictions will remain in place until I give written notice to the Office of the Registrar to release the restrictions.

Applicant's signature _____ Date _____

Please print and fax this completed form to 575-624-7144.

EASTERN NEW MEXICO UNIVERSITY-ROSWELL
INFORMATION RELEASE

Student's Name _____ Social Security # or Student ID # _____ Phone Number _____

I_____, hereby give my consent to ENMU-Roswell to release my Admissions, Records, Financial Aid, Student account, Card Services (Dining account) and or Special Services records and information either in verbal, written and/or electronic form E-mail and fax) to the staff and or faculty members of ENMU-Roswell and to the person(s) and or Third Party Agency listed below. This person(s) or agency has access to my information for the 21|22 academic year, which includes the fall, spring and summer semesters. I understand this release cannot exceed one academic year. The person listed below may have any information they request regarding:

All documentation in my files and any information

Please check all that apply:

- ☐ Admissions and Records (Application and/or Transcripts, etc...)
- ☐ Financial Aid (Pell grant/Scholarships)
- ☐ Special Services
- ☐ Business Office (Student account)
- ☐ Card Services (Dining card)
- ☐ La Casa Family Health Center: (Medication list, Progress Notes, Insurance card)
- ☐ Great Western Dining
- ☐ NEEBO
- ☐ Sierra Vista Village
- ☐ TRIO PROGRAM
- ☐ _____ DYR
- ☐ The following may **NOT** be released

The information checked in the boxes above may be released to:

Name (printed)	Relationship to student	Phone Number
Name (printed)	Relationship to student	Phone Number
Name (printed)	Relationship to student	Phone Number

A picture ID must be presented when submitting the information release. **This form must be notarized to be valid. If guardianship is in place, guardian must sign, also please submit a copy of guardianship documents.**

Student/ Signature _____ **Date signed** _____

Guardian Signature _____ **Date signed** _____

Notary Public
State of _____)
County of:)
)

Signed and sworn to before me by _____ on the day_____ of _____, 20_____

My Commission expires: _____
Notary Public

FOR OFFICE USE ONLY:

Received by:	Date:
Picture ID type:	ID Number:

TRANSCRIPT REQUEST FORM

EASTERN NEW MEXICO UNIVERSITY – ROSWELL

OFFICE OF ADMISSIONS & RECORDS

Number of copies requested (max is 5): _____ Date: _____

PLEASE PRINT NAME AND ADDRESS OF PERSON RECEIVING TRANSCRIPT:

_____

_____

_____

_____

Failure to provide a correct and complete address may result in returned mail or incorrect delivery. If no address is provided, your request will not be processed. If your transcript is returned because of an incorrect or insufficient address, we will not resend the transcript until a corrected address has been provided. It is your responsibility to ensure the address is correct.

ALL TRANSCRIPT REQUESTS MUST BE WRITTEN—NO TELEPHONE REQUESTS

Student Information:

Social Security Number ___ ___ ___ --___ ___--___ ___ ___ ___

Date of Birth ___ ___/ ___ ___/ ___ ___ ___ ___
Month Day Year

Full Name _____
Last First MI

Previous Name(s)_____

Address _____
Street

_____
City State Zip

Telephone: Daytime: _____ Cell:_____

Year of Last Enrollment: _____

Check one:

___Send Immediately ___Courses in Progress, Hold for Grades ___Hold for Degree Posting

By signing below, I agree that the information provided is accurate to the best of my knowledge. I agree I have provided a complete and correct mailing address to the recipient. I also understand that all transcripts are mailed via US Postal Service First Class Mail, which does not provide tracking information. I understand that delivery is not guaranteed by ENMU-Roswell and that it is my responsibility to ensure that transcripts are delivered.

Student signature (Typed Signatures NOT Accepted)_____

Pursuant to provisions of the Federal Family Educational Rights and Privacy Act of 1974, (Public Law 93-3801), I grant permission for release of my academic record of the individual indicated, but only on the condition that they will not permit any other party to have access to this records.

Completed and signed forms can be submitted via fax to (575) 624-7144, via email to records@roswell.enmu.edu, or via US Postal Service to ENMU-Roswell, ATTN: Records, PO Box 6000, Roswell, NM 88202

SIERRA VISTA
VILLAGE

Housing Application

1. Please submit your housing application to Sierra Vista Village along with the following fees:

   Refundable security deposit: $200

   The security deposit is refundable before your lease is signed and will then be held by management for the term of the lease.

2. Accommodations are limited and will be leased on a first-come, first-served basis. The acceptance of this application does not ensure an accommodation. An accommodation is reserved only upon execution of the lease agreement by all parties. Rates/installments, fees and utilities included are subject to change. Rates/installments do not represent a monthly rental amount (and are not prorated), but rather the total base rent due for the lease term divided by the number of installments.

3. For information or assistance in completing this application, please contact our office at 575.347.7132.

Applicant Information

Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Current Local Address: _____
(STREET) (CITY) (STATE) (ZIP)

Permanent Address: _____
(STREET) (CITY) (STATE) (ZIP)

Cell Phone: (____) _____ Other Phone: (____) _____

Email Address: _____

Social Security No: ____-____-____ Date of Birth: ____/____/____ ☐ Male ☐ Female

Please provide the information for one of the items below and check the corresponding choice:

☐ Driver's License ☐ Passport ☐ State ID Number: _____ State: _____

Are you a student? ☐ Yes ☐ No If yes, what school: _____

Fall 2019 Standing: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate Major: _____

What is your current employment occupation if your not a current student: _____

Have you ever been convicted of a felony? ☐ Yes ☐ No Reason: _____

Have you ever been evicted from any residence? ☐ Yes ☐ No Reason: _____

Have you ever filed bankruptcy? ☐ Yes ☐ No If yes, when: _____

Guarantor Information

Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Cell Phone: (____) _____ Other Phone: (____) _____

Email Address: _____

Date of Birth: ____/____/____ Social Security No: ____-____-____

Has the guarantor ever filed bankruptcy? ☐ Yes ☐ No If yes, when: _____

Emergency contact other than guarantor: _____

Cell Phone: (____) _____ Other Phone: (____) _____

Parking/Vehicle Information

Will you need parking? ☐ Yes ☐ No

Vehicle Make: _____ Model: _____

License Plate Number: _____ Year: _____

Floor Plan Selection

☐ 1 Bedroom + 1 Bathroom Deluxe ☐ 2 Bedroom + 1 Bathroom Deluxe ☐ 2 Bedroom + 1 Bathroom ☐ 4 Bedroom + 2 Bathroom

Roommate Request

If you have already chosen your roommate(s), please list their information below. All roommate choices must be mutual in order to be placed together. If you do not have a full apartment group, you will be matched with roommates based on your resident profile form. Unfortunately, roommate requests cannot be guaranteed.

NAME:	CELL PHONE:	EMAIL:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Text Message Alerts

_____ By initialing in the space provided, Applicant provides his/her express consent authorizing Sierra Vista Village to send Applicant text messages regarding community events, rent payments, property operations and leasing, delivered via automated technology, to the wireless number(s) that Applicant has provided above. Applicant understands that his/her consent is not required to rent from Sierra Vista Village.

_____ By initialing in the space provided, Applicant represents that he/she is 18+ years of age and that Applicant has read and agreed to the Terms of Use and Privacy Policy. Message and data rates may apply. Applicant may receive approximately ten (10) messages per month. Reply HELP for help. Reply **STOP** to cancel.

Acknowledgment

If you fail to answer any question, or if you have given false information: (1) we are entitled to reject this application; (2) we will retain all processing fees and deposits as liquidated damages for time spent and expenses; (3) we will terminate any right to lease the bedroom; and (4) if you have signed a lease, it will be a violation of the lease.

By my signature I attest that the information contained herein is correct. The management is authorized to verify my credit history, and all other submitted information for the purpose of evaluating this lease application.

This application will be approved upon satisfactory criminal background check.

Applicant Signature: _____ Date: _____

Rates/installments & fees subject to change. Rates/installments do not represent a monthly rental amount (and are not prorated), but rather the total base rent due for the lease term divided by the number of installments. Limited time only. Parking is available on a first-come, first-served basis.

Special Services

Occupational Training Program

Special Services Medical Statement

ENMU-Roswell maintains a health clinic at scheduled times during the week, which is open to all students of the university. A certified family nurse - practitioner is on duty at these times to provide limited health care services. During their stay at ENMU-Roswell, we strongly encourage students to designate a doctor in the Roswell area as their primary care physician and choose a pharmacy where prescriptions can be called into and the student can pick up.

If a student becomes ill while attending ENMU-Roswell, it will be the responsibility of the student to make and keep doctor's appointments, transport himself/herself to the doctor's office, obtain prescribed medication(s), and administer his/her own medications. In the event of an emergency, an ambulance will be called and student/parents may be responsible for all costs (ambulance, ER, etc.) incurred relating to the incident. It is the student's/parent's responsibility to insure their insurance coverage will be accepted at the primary care physician's office and designated pharmacy. Students/parents are ultimately responsible for payment of all health care costs. Parents/guardians will be responsible for retrieving the student should he/she need to return home.

I have read and understand the ENMU-Roswell Special Services Medical Statement:

Signature of Student: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Valid for the 20____ - 20____ school year

Revised 08/18/2020

ENMU-ROSWELL STUDENT HEALTH CENTER SPECIAL SERVICES DEPARTMENT

REGISTRATION, CONSENT TO TREAT, AND RELEASE OF INFORMATION

TODAY'S DATE: _____ DATE OF BIRTH: _____

FULL NAME: _____

PERMANENT ADDRESS: _____

CITY/STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

PHONE NUMBER: _____

PARENT/GUARDIAN FULL NAME: _____

PHONE NUMBER: _____ ALT. PHONE NUMBER: _____

PLEASE PROVIDE A COPY OF A CARD FOR ANY HEALTH INSURANCE/PHARMACY COVERAGE YOU MAY HAVE:

HEALTH INSURANCE: _____ PHONE: _____

PRESCIPTION SERVICES: _____ PHONE: _____

DENTAL INSURANCE: _____ PHONE: _____

PRIMARY CARE PHYSICIAN/CLINIC: _____

ADDRESS: _____

PHONE NUMBER: (_____) _____

EMERGENCY CONTACT: _____ RELATION: _____

PHONE NUMBER: (_____) _____ ALT. PHONE NUMBER: _____

☐ I DO CONSENT TO RECEIVE SERVICES OFFERED BY LA CASA FAMILY HEALTH CENTER

☐ I DO NOT COSENT TO RECEIVE SERVICES OFFERED BY LA CASA FAMILY HEALTH CENTER

IN SIGNING THIS RELEASE OF INFORMATION, I GIVE PERMISSION FOR LA CASA FAMILY HEALTH CENTER STAFF TO OBTAIN AND RELEASE COPIES OF MEDICAL RECORDS AND SHARE OTHER MEDICAL INFORMATION WITH HEALTH CARE PROVIDERS, PARENTS/GUARDIANS, AND ENMU – ROSWELL STAFF AS NECESSARY FOR LEGITIMATE MEDICAL CARE.

SIGNATURE: _____ DATE: _____

(VALID FOR THE 20___ - 20___ SCHOOL YEAR)

LA CASA
Family Health Center

REGISTRATION FORM

Patient Information:						
Patient Name			Preferred Name	Patient #	Current Date	
SSN	DOB	Age	Race	Ethnicity	Sex	
Address			City, State, Zip Code			
Home Phone	Mobile Phone		Patient E-mail		Registered by:	

Guarantor Information:				
Guarantor Name	SSN	DOB	Current Date	
Address	City, State, Zip Code			
Home Phone	Mobile Phone	Guarantor E-mail		

Insurance Information:		
Primary Insurance	Plan Number	Primary Card Holder
Secondary Insurance	Plan Number	Primary Card Holder

AUTHORIZATION FOR CARE:
I hereby authorize any medical or surgical care which is considered by the staff of La Casa Family Health Center, and for their contracting physicians to be in my or members of my family's best interest and authorize the release of any information required in the course of registration, examination, or treatment.

MEDICAID RELEASE OF RECORDS:
If I am a Medicaid recipient, I allow La Casa Family Health Center to release my records to the New Mexico Human Services Department, the United Sates Department of Health and Human Services, and the Medicaid Fraud Unit, and their designated representatives, allowing them access to all records to the provision of service which is to include on site inspections review and copying.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize payment of medical benefits to La Casa Family Health Center.

ADDITIONAL CHARGES:
I understand that my payment of $_____has been applied to my account and any other charges for my visit will be billed to me. I understand any additional services are my responsibility.

NON-COVERED RELEASE:
As my medical provider, La Casa Family Health Center has informed me that services received may be denied by my insurance and/or Medicare. I agree to be fully responsible for payment of these services.

My signature indicates that I have reviewed and confirmed the above patient, guarantor and insurance information.

_____ _____ _____
Signature **Relationship** **Date**

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for this visit? _____

SYMPTOMS Check (✓) Symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
Chills	Appetite poor	Bleeding gums	Breast lump
Depression	Bloating	Blurred vision	Erection difficulties
Dizziness	Bowel changes	Crossed eyes	Lump in testicle
Fainting	Constipation	Difficulty swallowing	Penis discharge
Fever	Diarrhea	Double vision	Sore in penis
Forgetfulness	Excessive hunger	Earache	Other
Headache	Excessive thirst	Ear discharge	
Loss of sleep	Gas	Hay fever	**WOMEN only**
Loss of weight	Hemorroids	Hoarseness	Abnormal Pap Smear
Nervousness	Indigestion	Loss of hearing	Bleeding between periods
Numbness	Nausea	Nosebleeds	Breast lump
Sweats	Rectal bleeding	Persistent cough	Extreme menstrual pain
MUSCLE/JOINT/BONE Pain, weakness, numbness in:	Stomach pain	Ringing ears	Hot flashes
	Vomiting	Sinus problems	Nipple discharge
Arms / Hips	Vomiting blood	Vision – flashes	Painful intercourse
Back / Legs	**CARDIOVASCULAR**	Vision – Halos	Vaginal discharge
Feet / Neck	Chest pain	**SKIN**	Other :
Hands / Shoulders	High blood pressure	Bruise easily	Date of last –
GENITO-URINARY	Irregular heart beat	Hives	Menstrual period / /
Blood in urine	Low blood pressure	Itching	Pap smear / /
Frequent urination	Poor circulation	Change in moles	Have you had a
Lack of bladder control	Rapid heart beat	Rash	Mammogram? Y N
Painful urination	Swelling of ankles	Scars	Are you pregnant?
	Varicose veins	Sore that won't heal	Number of children

CONDITIONS Check (✓) if you have or have had in the past

Aids	Chemical dependency	High Cholesterol	Prostate Problem
Alcoholism	Chicken Pox	HIV Positive	Psychiatric Care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema	Liver Disease	Scarlet Fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headache	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding disorders	Gonorrhea	Mononucleosis	Tonsillitis
Breast lump	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Typhoid Fever
Bulemia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal Infections
Cataracts	Herpes	Polio	Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** to medications and substances
Pharmacy Name: Phone #	

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications, if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use

- ☐ Caffeine
- ☐ Tobacco
- ☐ Drugs
- ☐ Other

Have you ever had a blood transfusion? Yes _____ No _____
If yes, please give appropriate dates: _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following

- ☐ Stress
- ☐ Hazardous Substances
- ☐ Heavy Lifting
- ☐ Other

Your occupation: _____

1. Do you eat away from home? _____Yes _____No If yes, how many times per week? _____
   Where? _____
2. Do you engage in physical activity? _____ Yes _____ No If no, why not? _____
   If yes, how frequently? 30 mins/day ___ 1 – 2 times/ week ___
   3 – 4 times/week ___ 5 – 6 times/ week ___
3. Do you feel safe at home? Yes _____ No _____ If no, why? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature _____ Date

_____ Reviewed by _____ Date

LCFHC 06-20-01

LA CASA
Family Health Center

Knowing Your Patient Responsibilities

1. **Provide Information:**
   Providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health to the best of their knowledge. Reporting perceived risks in the patient's care, and/or unexpected changes in the patient's condition. Providing feedback about service needs and expectations, thereby helping La Casa Family Health Center improve its provision of patient care.

2. **Ask Questions:**
   Following the care, service, or treatment plan developed. They should express any concerns they have about their ability to understand, follow, and comply with the proposed care plan or course of treatment.

3. **Follow Rules and Regulations:**
   Following the care, service, or treatment plan developed. They should express any concerns they have about their ability to understand, follow, and comply with the proposed care plan or course of treatment.

4. **Accept Consequences:**
   The outcome of the patient's condition if they do not follow the care, services, or treatment plan.

5. **Follow rules and Regulations:**
   Following La Casa Family Health Center rules and regulations concerning patient care and conduct, including appropriate notification for canceling scheduled appointments.

6. **Show Respect and Consideration:**
   Being considerate and respectful of La Casa Health Center personnel and property.

7. **Meet Financial Commitments:**
   Promptly meeting any financial obligation agreed to with La Casa Family Health Center.

Patient Signature	Date
Print Name	Date
La Casa Employee Signature	Date

LA CASA
Family Health Center

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our Privacy Practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I,_____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Signature of Parent or Patient's Representative (if applicable) Date

_____
Description of Legal Authority to Act on Behalf of Patient

LA CASA
Family Health Center

New Mexico Living Will AND/OR New Mexico Durable Power of Attorney

(In compliance with the Patient Self-determination Act 1990)

Patient Self-determination Information Verification

1. Do you have a LIVING WILL (Right to Die) document? ☐ YES ☐ NO

2. Do you have a DURABLE POWER of ATTORNEY for Health Care Decisions? ☐ YES ☐ NO

If yes, complete the following information:

Where is it located? _____

Information on Individual with Durable Power of Attorney and/or Living Will for Health Care Decisions:

Name: _____ Phone: ( ) _____

Address: _____

City: _____ State _____ Zip _____

If yes, place a copy of LIVING WILL (Right to Die) and/or DURABLE POWER of ATTORNEY for healthcare decisions in medical record.

Date copy requested: _____

Information obtained from: _____

Relationship to Patient: _____

If no, information concerning advance medical directives, including information describing the DURABLE POWER of ATTORNEY and LIVING WILLS has been given to this patient.

_____ _____

Patient Signature **Date**

_____ _____

Staff Signature **Date**

La Casa Family Health Center
Notice of Privacy Practices

Effective Date: July 11, 2006

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

For More Information, Please Contact Us:

Tammy Jones
Practice Manager/ Privacy Officer
La Casa Family Health Center
1515 W. Fir, PO Box 843
Portales, NM 88130
(575) 356-6695

Who We Are:

This Notice describes the privacy practices of La Casa de Buena Salud, Inc., and the privacy practices of:

- all of our doctors, nurses, and other health care professionals authorized to enter information about you into your medical chart.
- all of our departments, including, *e.g.*, our medical records and billing departments.
- all of our health center sites La Casa de Buena Salud, Inc
- all of our employees, staff, volunteers and other personnel who work for us or on our behalf.

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

We are required by law to:

- make sure that health information that identifies you is kept private in accordance with relevant law.
- give you this notice of our legal duties and privacy practices with respect to your personal health information.
- follow the terms of the notice that is currently in effect for all of your personal health information.

How We May Use and Disclose Your Health Information:

We may use and disclose your personal health information for these purposes:

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to the doctors, nurses, technicians, medical students and others who are involved in your care. They may work at the Health Center, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy or other health care provider to whom we may refer you for treatment, consultation, x-rays, lab tests, prescriptions or other health care service. They may also include doctors and other health care professionals who work at the Health Center, or elsewhere, whom we consult about your care. For example, we may consult with a specialist who lends his/her services to the Health Center about your care or disclose to an emergency room doctor who is treating you for a broken leg that you have diabetes, because diabetes may affect your body's healing process.

For Payment. We may use and disclose health information about you to bill and collect payment from you, your insurance company, including Medicaid and Medicare, or other third party that may be available to reimburse us for some or all of your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you need to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for our day-to-day operations, and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations. These uses and disclosures are necessary to run the Health Center and to make sure that all of our patients receive quality care, and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients with health information from other health care providers to decide what additional services the Health Center should offer, what services are not needed, whether new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our patients are.

Appointment Reminders. We may use and disclose health information about you to contact you as a reminder that you have an appointment at the Health Center via phone call and/or text (SMS) message.

Health-Related Services and Treatment Alternatives. We may use and disclose health information to tell you about health-related services or recommend treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address when sending this information to you.

Personal Representative. We may release health information about you to a friend or family member who is involved in your health care provided they have power of attorney, legal **guardianship or notarized letter**.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with a patient's need for privacy. Before we use or disclose health information for research, the project will have been approved through this special approval process, although we may disclose health information about you to people

preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care.

Organ and Tissue Donation. If you are an organ donor, we may disclose health information about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

As Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/ discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability.
- to report births and deaths.
- to report child abuse or neglect.
- to report reactions to medications or problems with products.
- to notify people of recalls of products.
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process that is not accompanied by a court or administrative order, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information about you if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process.
- to identify or locate a suspect, fugitive, material witness or missing person.
- under certain limited circumstances, about the victim of a crime.
- about a death we believe may be the result of criminal conduct.
- about criminal conduct at the Health Center.
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information about our patients to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as may be necessary for them to carry out their duties.

National Security and Intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the corrections institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the correctional institution.

Your Rights:

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them:

Right to Inspect and Copy: You have the right to inspect and copy the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of the applicable fee, provide you with a summary of these notes.

To inspect and copy your personal health information, you must submit your request in writing to our privacy contact person identified on the first page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. The person conducting the review will not be the same person

who denied your request. We will comply with the outcome of this review. Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for any information that we maintain about you. To request an amendment, your request must be made in writing, submitted to our privacy contact person identified on the first page of this notice, and must be contained on one piece of paper legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or organization that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for the Health Center,
- is not part of the information which you would be permitted to inspect and copy, or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to the health care professionals involved in your care and to others to carry out payment and health care operations, as previously described in this notice.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your health information that we have made. Any accounting will not include all disclosures that we make. For example, an accounting will not include disclosures:

- to carry out treatment, payment and health care operations as previously described in this notice.
- pursuant to your written authorization.
- to a family member, other relative, or personal friend involved in your care or payment for your care when you have given us permission to do so.
- to law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to our privacy contact person identified on the first page of this notice. Your request must state a time period which may not be more than six (6) years and may not include dates before **April 14, 2003**. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; this date will not exceed 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we do agree, however, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our privacy contact person identified on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Receive Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way. For example, you can ask that we only contact you at work or by mail to a specified address.

To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the first page of this notice.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

[Tammy Jones]
[Privacy Officer]
[La Casa Family Health Center]
[PO Box 843, 1515 W. Fir]
[(575) 356-6695]

Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information:

Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we have provided to you.

LA CASA
Family Health Center

DENTAL CLINIC
Cancelled and Missed Appointment Policy

A policy has been secured for patients who make appointments but fail to show up or decline to give adequate notice of cancellation. Missed or cancelled appointments without proper notice cause delays for the dental clinic.

A patient is only allowed two (2) missed appointments per six-month period. The missed appointment will be noted in the patient's chart.

An appointment is considered missed if:

1. The patient fails to show up for the appointment; or
2. The patient is more than 10 minutes late for a scheduled appointment without a phone call made to the dental clinic; or
3. The patient calls to cancel an appointment without giving a 24-hour notice.

If a patient accumulates two missed or cancelled appointments without proper notice in a six-month period, the patient will not be allowed to reschedule any further routine appointments for the next six months. The patient will be limited to emergency care on a space available basis during the six month period.

Family Member(s) in Dental Treatment Room Policy

In order to provide the highest quality of care, safety and efficiently to our dental patients, all family members and friends are required to remain in the waiting area while dental treatment services are being rendered. This policy will help La Casa Family Health Center to ensure safety, infection control and patient confidentiality.

NOTICE TO PARENT(S) OF MINOR CHILDREN

Experts in the field of pediatric dentistry universally agree that children are much more cooperative and attentive when parents are not present during dental treatment. In the event you presence is required in the dental operatory, you will be asked to join. With an especially resistant or frightened child, referral to a specialist might be necessary.

Refusal to adhere to these policies could result in rescheduling until the parent feels that their child can handle routine dental care on their own.

I have read and understand the policies noted above for the La Casa Family Health Center Dental Clinic.

Patient Name _____ Date _____

Patient or Guardian Signature _____

LA CASA Family Health Center

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help!

Patient Information (CONFIDENTIAL)

Name_____ Birth Date_____

Physician_____ Date of Last Exam_____

Person to Contact in Case of Emergency_____ Phone_____

Patient Medical History

	Y/N
1.) Are you under medical treatment now?	☐ ☐
2.) Have you been hospitalized in the past 5 years?	☐ ☐
3.) Do you use tobacco?	☐ ☐
4.) Do you take any blood thinners including Aspirin?	☐ ☐
5.) Have you had a persistent cough for more than 3 weeks?	☐ ☐
6.) Women Only:	
a. Are you pregnant or think you may be pregnant?	☐ ☐
b. Are you nursing?	☐ ☐
c. Are you taking oral contraceptives?	☐ ☐
7.) Are you taking bisphosphonate drugs for bone disease? (i.e. Zometa, Fosamax, Boniva)	☐ ☐

8.) Are you allergic to or have you had any reactions to the following?	Y/N
a. Local Anesthetics (Novocaine)	☐ ☐
b. Penicillin	☐ ☐
c. Sulfa Drugs	☐ ☐
d. Codeine	☐ ☐
e. Any Metals (Mercury)	☐ ☐
f. Latex Rubber	☐ ☐
g. Other _____	☐ ☐

9.) Do you have or have you had any of the following? (Please check all that apply)

AIDS/HIV Infection ☐	Fainting/Seizures ☐	Liver Disease ☐
Anemia ☐	Glaucoma ☐	Mitral Valve Prolapse ☐
Angina ☐	Hay Fever/Allergies ☐	Radiation Therapy ☐
Arthritis ☐	Heart Attack ☐	Respiratory Problems ☐
Asthma ☐	Heart Disease ☐	Rheumatic Fever ☐
Cancer ☐	Heart Murmur ☐	Sexually Transmitted Disease ☐
Cardiac Pacemaker ☐	Hepatitis ☐	Stomach Problems/Ulcers ☐
Chest Pain ☐	High Blood Pressure ☐	Stroke ☐
Diabetes ☐	Jaundice ☐	Thyroid Problems ☐
Emphysema ☐	Joint Replacement/Implant ☐	Tuberculosis ☐
Epilepsy/Convulsions ☐	Kidney Disease ☐	Other_____ ☐

Patient Dental History

	Y/N
1.) Do your gums bleed while brushing or flossing?	☐ ☐
2.) Are your teeth sensitive to hot or cold?	☐ ☐
3.) Are your teeth sensitive to sweet or sour?	☐ ☐
4.) Do you feel pain in any of your teeth?	☐ ☐
5.) Do you wear partials or dentures?	☐ ☐
6.) Have you had any head, neck, or jaw injuries?	☐ ☐
7.) Do you have frequent headaches?	☐ ☐
8.) Do you clench or grind your teeth?	☐ ☐
9.) Do you bite your lips or cheeks frequently?	☐ ☐

	Y/N
10.) Have you had any orthodontic treatment?	☐ ☐
11.) Have you received instruction regarding the care of your teeth and gums?	☐ ☐
12.) Have you had your teeth cleaned in the last year?	☐ ☐
13.) Have you had any difficult extractions?	☐ ☐
14.) Have you had prolonged bleeding following extractions?	☐ ☐
15.) Do you like your smile?	☐ ☐

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and the health of others.

X_____ _____

Signature of Patient (or parent/guardian if minor) Date

Dr. Notes

Office use ONLY

FY 21/22 ***ESTIMATED*** Costs for Special Services Program

Tuition, Fees, and Meal Plan are subject to change by the Board of Regents.

NON-RESIDENT:

TUITION & FEES	FALL COST	SPRING COST	SUMMER COST
Tuition	$3352	$3352	$2180
Required Fees	224	224	160
Special Services Fees	1771	1771	886
Life Skills Fee	30	30	30
Independent Living Lab Fee	30	30	30
CPR Card Fee	--	--	20
Fingerprinting Fee (Child Care ONLY)	44	--	--
Course Fee (Food Service ONLY)	30	30	30
Technology Fee	15	15	15
Liability Policy	5	5	5
Bus Pass	32	32	13
TOTAL Tuition & Fees	$5459 to $5533	$5459 to $5533	$3339 to 3369
MEAL PLAN	$1735	$1735	$1005

TEXTBOOKS (for the whole year) ~ $550 - 825

HOUSING @ Sierra Vista Village
~ $375/mo with 12 month lease = ~$4500 for the year (+ $200 deposit)

SUPPLIES and Required Clothing Items: ~$300 (includes $18 cost for Nametag)

TOTAL Cost for the 3 Semesters for NM Non-Resident Student (Tuition, Fees, Meals, Books, Housing, Supplies) = approximately $24,500

FY 21/22 ***ESTIMATED*** Costs for Special Services Program

Tuition, Fees, and Meal Plan are subject to change by the Board of Regents.

NM OUT-OF-DISTRICT (Outside of Chaves County):

TUITION & FEES	FALL COST	SPRING COST	SUMMER COST
Tuition	$1190	$1190	$850
Required Fees	224	224	160
Special Services Fees	1771	1771	886
Life Skills Fee	30	30	30
Independent Living Lab Fee	30	30	30
CPR Card Fee	--	--	20
Fingerprinting Fee (Child Care ONLY)	44	--	--
Course Fee (Food Service ONLY)	30	30	30
Technology Fee	15	15	15
Liability Policy	5	5	5
Bus Pass	32	32	13
TOTAL Tuition & Fees	$3297 to 3341	$3297 to 3341	$2009 to $2039
MEAL PLAN	$1735	$1735	$1005

TEXTBOOKS (for the whole year) ~ $550 - 825

HOUSING @ Sierra Vista Village
~ $375/mo with 12 month lease = ~$4500 for the year (+ $200 deposit)

SUPPLIES and Required Clothing Items: ~$300 (includes $18 cost for Nametag)

TOTAL Cost for the 3 Semesters for NM Out-of-District Student (Tuition, Fees, Meals, Books, Housing, Supplies) = approximately $19,000

FY 21/22 ***ESTIMATED*** Costs for Special Services Program

Tuition, Fees, and Meal Plan are subject to change by the Board of Regents.

NM IN-DISTRICT (Chaves County residents):

TUITION & FEES	FALL COST	SPRING COST	SUMMER COST
Tuition	$1092	$1092	$780
Required Fees	224	224	160
Special Services Fees	1771	1771	886
Life Skills Fee	30	30	30
Independent Living Lab Fee	30	30	30
CPR Card Fee	--	--	20
Fingerprinting Fee (Child Care/Office Skills ONLY)	44	--	--
Course Fee (Food Service ONLY)	30	30	30
Technology Fee	15	15	15
Liability Policy	5	5	5
Bus Pass	32	32	13
TOTAL Tuition & Fees	$3199 to $3273	$3199 to $3273	$1939 to $1969
MEAL PLAN	$1735	$1735	$1005

TEXTBOOKS (for the whole year) ~ $550 - 825

HOUSING @ Sierra Vista Village
~ $375/mo with 12 month lease = ~$4500 for the year (+ $200 deposit)

SUPPLIES and Required Clothing Items: ~$300 (includes $18 cost for Nametag)

TOTAL Cost for the 3 Semesters for NM Out-of-District Student (Tuition, Fees, Meals, Books, Housing, Supplies) = approximately $18,700