Dear Interested Student for the 2023/2024 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 Services Program. The student will need to sign or initial where stated. All pages of the application will need to be returned along with any attachments required. We will be accepting applications for Fall 2023 enrollment until May 1, 2023. 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@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

Rebecca L. Cobos, MSW
Director of Special Services
Phone: 575-624-7289
Email: rebecca.cobos@enmu.edu

Checklist for a Complete Application Packet
2nd, 3rd, or 4th Year Vocational Certificate

Please initial next to each item completed

_____ **1.** Application for ENMU Roswell Special Services
_____ **2.** Entrance Requirements
_____ **3.** ENMU Roswell Application for Undergraduate Admissions
_____ **4.** ENMU Roswell Information Release (must be notarized-mail original)
_____ **5.** Guardianship and/or Power of Attorney Forms (if applicable)
_____ **6.** Sierra Vista Village Housing Application
_____ **7.** Special Services Medical Statement
_____ **8.** ENMU Roswell Health Information Form
_____ **9.** ENMU Roswell Health Registration, Consent to Treat, and Release of Information
_____ **10.** La Casa Health Center Forms
_____ **11.** Copy of Medical/Dental/Vision Insurance Card(s)
_____ **12.** Copy of State Identification Card/Social Security Card
_____ **13.** Essay "How I Will Benefit from a 2nd, 3rd, or 4th Year Vocational Certificate"

Mail Completed Application Packet to:

ENMU Roswell
Special Services
PO Box 6000
Roswell, NM 88202

Special Services Program

Application for Eastern New Mexico University Roswell Special Services Program
2023-2024Academic 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: _____

Parent Mailing Address: _____

_____

Parent/Guardian Cell Phone: _____

Parent/Guardian Email Address: _____

Parent/Guardian: _____

Parent Mailing Address: _____

_____

Parent/Guardian Cell Phone: _____

Parent/Guardian 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. Student's must independently follow prescribed plans as follows:
    a. Seizure plan signed from a medical provider.
    b. Diabetes plan and/or other medical plans signed from a medical provider.
    c. Asthma plan signed by a medical provider
    d. Mental Health Plan signed by a mental health provider.
5. Independently awaken to an alarm. Attend classes and practicum regularly and on time.
6. Be able to independently utilize public transportation.
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. COVID – 19 Vaccine is recommended if going into Child Care Attendant Program.
11. Full disclosure and documentation of any past legal issues
12. Students are required to live in the Sierra Vista Dorms.
13. Students are required to purchase a meal plan for the cafeteria.
14. 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 states:

"We understand the above entrance requirements"

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

Application for Undergraduate Admission

EASTERN NEW MEXICO UNIVERSITY — ENMU-Ruidoso — ENMUR

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

D Male D 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? D Yes D 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: D Yes D No

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

D American Indian or Alaska Native D Asian D Black or African American

D Native Hawaiian or other Pacific Islander D 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? D Yes D 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? D Yes D No Is your spouse active duty military? D Yes D No

Are either of your parents active duty military? D Yes D No

If yes, are you or your parents stationed in New Mexico? D Yes D 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? D Yes D No

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

Enrollment Information

Campus where you plan to enroll

D Portales D Ruidoso D Roswell

Semester you plan to start

D Fall D Spring D Summer Year ☐☐☐☐

Your enrollment status

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

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

Intended degree

*Nondegree not eligible for financial aid.

D Certificate
D Associate's degree
D Bachelor's degree
D Second bachelor's degree
D *Nondegree: updating job skills
D *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? D Yes D No

High school graduation

High school diploma? D Yes D No
Home school diploma? D Yes D No

Graduation date: ☐☐/☐☐☐☐ Month Year

or GED completion

GED certificate? D Yes D 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

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 2022 Standing: □ Freshman □ Sophomore □ Junior □ Senior □ Graduate Major:_____

What is your current employment occupation if you're 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: _____

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, 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, 2023/2024 academic year which includes the fall, spring and summer semesters. I understand this release cannot exceed one academic year. The person(s) 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)
- ☐ Follett Bookstore
- ☐ La Casa Family Health Center: (Medication list, Progress Notes, Insurance card)
- ☐ La Casa Behavioral Health
- ☐ Summit Dining
- ☐ Sierra Vista Village
- ☐ TRIO Program
- ☐ DVR or DARs
- ☐ Workforce Connections

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

Name (print)	Relationship to student	Phone number
Name (print)	Relationship to student	Phone number
Name (print)	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 swore 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:

EASTERN NEW MEXICO UNIVERSITY – ROSWELL
INFORMATION RELEASE FORM

Student's Name _____ Student ID# _____ Telephone Number _____

I,_____, hereby give ENMU-Roswell consent to release my Admissions, Records, Financial Aid, Student Account and/or Special Services records and information in either verbal, written or electronic form (i.e. e-mail/fax) to the staff and/or faculty members of the third party agency or person(s) listed below. This agency/person will have access to my information for the _____ academic aid year, which includes the fall, spring and summer terms. I understand this release is only valid for the current academic aid year and must be renewed upon expiration for any further terms. The agency/person listed below may have access to the information they are requesting regarding the following:

Please check all that apply:

- o All documentation in my file for:
  - o Admissions and Records
    - ▪ Applications and/or transcripts
  - o Financial Aid
    - ▪ Pell Grant/Scholarships
    - ▪ Third party grants
    - ▪ Budget and/or other award information
  - o Special Services
  - o Business Office
    - ▪ Student account information
    - ▪ Balances and/or credits
  - o The following may **NOT** be released:
  - o _____
  - o _____
  - o _____

The information checked in the above box(es) above may be released to:

_____ _____
Name/Agency Relationship to student

_____ _____
Name/Agency Relationship to student

NOTE: The student and the requesting agency/person(s) is required to be present when completing this form and also provide a current picture ID. If the requesting agency/person(s) is/are not available, the release must be notarized below in order to be valid.

_____ _____
Student's signature Date

_____ _____
Notary Public Expiration Date Date

FOR OFFICE USE ONLY:

Received by:	Date:
Picture ID type:	ID number:

Special Services Medical Statement

ENMU-Roswell utilizes a community 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 ensure 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 10/12/2022**

EASTERN NEW MEXICO UNIVERSITY ROSWELL

Special Services Program

ENMU-ROSWELL STUDENT HEALTH CENTER SPECIAL SERVICES DEPARTMENT
REGISTRATION, CONSENT TO TREAT, AND RELEASE OF INFORMATION

TODAY'S DATE: _____ DATE OF BIRTH: _____

STUDENT FULL NAME: _____

PERMANENT ADDRESS: _____

CITY/STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

STUDENT PHONE NUMBER: _____

PARENT/GUARDIAN FULL NAME: _____

PARENT/GUARDIAN PHONE NUMBER(S): _____ / _____

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

HEALTH INSURANCE: _____ PHONE: _____

PRESCIPTION SERVICES: _____ PHONE: _____

DENTAL INSURANCE: _____ PHONE: _____

PRIMARY CARE PHYSICIAN/CLINIC: _____

ADDRESS: _____

PHONE NUMBER: _____ ALT. 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 CONSENT 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)

Student Name: _____ **Student DOB:** _____

Health History: Do you have any of the following? When were you diagnosed?		
PLEASE FILL OUT BOTH PAGES TO THE BEST OF YOUR KNOWLEDGE		
Condition	**Date of Diagnosis**	**Comments**
AMPUTATION		
ANOREXIA/OTHER EATING DISORDER (BE SPECIFIC)		
APHASIA		
ARTHRITIS DISORDERS (PLEASE SPECIFY)		
ASTHMA/RESPIRATORY ISSUES		
ATAXIA		
ATTENTION DEFICIT		
AUTISM/ASPERGER'S		
BACK DISORDERS (PLEASE SPECIFY)		
BLOOD DISORDERS (PLEASE SPECIFY)		
BRAIN/HEAD INJURY (PLEASE SPECIFY)		
CANCER (PLEASE SPECIFY)		
CEREBRAL PALSY		
CHRONIC FATIGUE SYNDROME		
CYSTIC FIBROSIS		
DEPRESSION		
DIABETES		
DOWN'S SYNDROME		
DYSLEXIA		
EPILEPSY/SEIZURE DISORDER		
GASTROINTESTINAL PROBLEMS		
GENITAL PROBLEMS (MALE)		
GYNECOLOGICAL PROBLEMS (FEMALE)		
HAY FEVER/SEASONAL ALLERGIES		
HEARING LOSS		
HEART DEFECT/DISEASE		
HIGH BLOOD PRESSURE		
HYPOGLYCEMIA		
INTELLECTUAL DISABILITY		
KIDNEY PROBLEMS		
MOOD DISORDERS		
NEUROMUSCULAR DISORDERS (PLEASE SPECIFY)		
OBESITY		
POST TRAUMATIC STRESS DISORDER		
RECURRENT BLADDER INFECTIONS		
SCHIZOPHRENIA/OTHER PERSONALITY DISORDERS		
SPINAL CORD INJURY (PLEASE SPECIFY)		
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY		
TOBACCO USE		
VISUAL DEFICITS (PLEASE SPECIFY)		

Student Name: _____ **Student DOB:** _____

ARE THERE ANY OTHER CONDITIONS/PROBLEMS WE NEED TO KNOW ABOUT?

_____
_____
_____

WHAT MEDICATIONS/VITAMINS/SUPPLEMENTS DO YOU TAKE? HOW MUCH? HOW OFTEN?

_____
_____
_____

LIST ANY KNOWN ALLERGY TO MEDICATION/FOOD/SUBSTANCES:

_____
_____
_____

Date Filled Out: _____

Student Signature: _____

Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

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 (Student) Signature Date

_____ _____
Print Patient (Student) Name Date

_____ _____
La Casa Employee 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

SOBRE NUESTRA NOTICIA DE PRATICAS DE PRIVACIDAD

Estamos comprometidos de proteger su información personal de salud en cumplimento con la ley. La Noticia de Practicas de Privacidad aplicada aquí le hace saber:

- Nuestras obligaciones bajo la ley con respecto a la información personal de salud.
- Como podemos usar y divulgar su información que tenemos aquí.
- Sus derechos sobre su información personal de su salud.
- Nuestros derechos de hacer cambios a la Noticia de Practicas de Privacidad.
- Como poner una queja si cree que sus derechos de privacidad han sido violados.
- Las condiciones que aplican a los usos y divulgaciones no descritos en esta Noticia
- A quien contactar para más información sobre nuestras practicas de privacidad.

Por ley, es necesario que le demos una copia de esta noticia y obtener su firma confirmando que usted ha recibido una copia esta noticia.

Confirmación de Recibido del Paciente

Yo,_____, por este medio confirmo que he recibido una copia de la Noticia de Practicas de Privacidad.

_____ _____/_____/_____
Firma del Paciente Fecha

_____ _____/_____/_____
Firma del Padre o Representante del Paciente (si aplica) Fecha

_____
Descripción de Autoridad legal de actuar en Nombre del Paciente

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

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

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

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 Email			Registered by:
Guarantor Information:					
Guarantor Name			SSN	DOB	Current Date
Address			City, State, Zip Code		
Home Phone	Mobile Phone	Patient Email			
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.

MEDICAL 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 States Department of Health and Human Services, and the Medicaid Fraud Unit and their designated representatives, allow them access to all records to the provision of service which is to include on site inspections review and copy.

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 these services.

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

_____ _____ _____

Signature Relationship Date

HEALTH HISTORY

(Confidential)

Student Name _____ Todays Date_____

Age _____ Birthday _____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			Bowl changes	Crossed eyes	Lump in testicle
	Fainting			Constipation	Difficulty swallowing	Penis discharge
	Fever			Diarrhea	Double vision	Score penis
	Forgetfulness			Excessive hunger	Earache	Other
	Headache			Excessive thirst	Ear discharge	
	Loss of sleep			Gas	Hay fever	**WOMEN only**
	Loss of weight			Hemorrhoids	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				Stomach pain	Ringing in ears	Hot flashes
Pain, weakness, numbness in:				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—
GENITOURINARY				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 in ankles	Scars	Are you Pregnant?
				Varicose veins	Sore that won't heal	Number of children

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

	Aids		Chemical Dependency		High Cholesterol		Prostate Problems
	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		Margarine Headache		Suicide Attempt
	Asthma		Goiter		Miscarriage		Thyroid Problems
	Bleeding disorders		Gonorrhea		Mononucleosis		Tonsillitis
	Breast lump		Gout		Mumps		Tuberculosis
	Bronchitis		Heart Disease		Multiple Sclerosis		Typhoid Fever
	Bulimia		Hepatitis		Pacemaker		Ulcers
	Cancer		Hernia		Pneumonia		Vaginal Infection
	Cataracts		Herpes		Polio		Venereal Disease

MEDICATIONS List medications you are currently taking.	ALERGIES to medications and substances
Pharmacy Name: Phone#	

(All information is strictly confidential)

FAMILY HISTORY Fill in the health information about your family

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

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes_____ No_____

If yes, please give appropriate dates: _____

SERIOUS ILLNESS/INJURIES

	DATE	OUTOCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications, if any

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

	Caffeine
	Tobacco
	Drugs
	Other

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

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

Do you eat away from home _____Yes _____No If yes, how many times per week? _____

Where? _____

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_____

Do you feel safe a home? _____Yes _____No _____ If no, why not? _____

_____

_____

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

_____ _____

Student Signature Date

_____ _____

Reviewed Date

LA CASA
COMMUNITY BEHAVIORAL HEALTH SERVICES

110 E Mescalero Rd. Roswell, NM 88201 575.755.2272

LAST NAME:	FIRST NAME:	MIDDLE NAME:
DATE OF BIRTH: / /	GENDER: MALE FEMALE Transgender Female to Male / Transgender Male to Female	SOCIAL SECURITY #: - -
MAILING ADDRESS:	CITY, STATE, ZIP CODE	
PHYSICAL ADDRESS:	CITY, STATE, ZIP CODE	

HOME PHONE ( )	DAY PHONE ( )	ALTERNATE PHONE: ( )	EMAIL ADDRESS:	PLEASE CHECK PREFERRED CONTACT: HOME PHONE DAY PHONE

FOR PATIENTS UNDER 18 YEARS OF AGE

MOTHER'S NAME:	MOTHER'S DAY PHONE: ( )	MOTHER'S DATE OF BIRTH: / /
FATHER'S NAME:	FATHER'S DAY PHONE: ( )	FATHER'S DATE OF BIRTH: / /
EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE NUMBER: ( )	

WHAT IS YOUR PRIMARY LANGUAGE? ENGLISH NAVAJO SPANISH SIGN OTHER	MARITAL STATUS: SINGLE MARRIED DIVORCED LEGALLY SEPARATED WIDOWED LIFE PARTNER UNKNOWN

RACE: NATIVE AMERICAN / ALASKAN NATIVE NATIVE HAWAIIAN ASIAN OTHER PACIFIC ISLANDER WHITE/CAUCASION BLACK/AFRICAN AMERICAN MORETHAN ONE RACE	CENSUS NUMBER (IHS):	Tribe:
STUDENT STATUS: Full Time Part Time Not a Student FAMILY FINANCES: To Qualify for Sliding Scale Fee You Must Provide Written Proof of All Household Income (ONLY IF YOU ARE APPLYING FOR SLIDING SCALE FEE)	Are you Employed? Yes or No	If No, do you Receive Unemployment? Yes or No

CURRENT LIVING SITUATION
Apartment or House (Rented or Owned) Live with Friends or Relatives (Doubling UP) Living on the streets (Car, Park or Shelter)

Name of your Doctor / PCP:	***ARE YOU HEARING IMPAIRED?*** Yes or No
PRIMARY INSURANCE COMPANY:	INSURANCE PHONE: ( )

INSURED PERSON	SOCIAL SECURITY NUMBER / /	DATE OF BIRTH: / /
INDIVIDUAL MEMBER NUMBER:	GROUP NUMBER:	EFFECTIVE DATE: / /
SECONDARY INSURANCE COMPANY:		INSURANCE PHONE: ( )
INSURED PERSON:	SOCIAL SECURITY NUMBER / /	DATE OF BIRTH: / /
INDIVIDUAL MEMBER NUMBER:		EFFECTIVE DATE: / /

I CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE AND CORRECT.

PATIENT/LEGAL GUARDIAN'S SIGNATURE DATE This form to be DATA ENTERED by LCBH Staff Date

110 E Mescalero Rd. Roswell, NM 88201 575.755.2272

Patient Name _____

Date of Birth _____

Financial Information Form

La Casa Family Health Center is required to collect and report certain demographic information to the Health Resources and Services Administration annually (you will not be identified personally). By providing your financial information, you may be eligible to receive a discount on your services.

I certify that my weekly / monthly / annual household income is _____

The number of people in my household is _____

LA CASA

Family Health Center

SLIDING SCAL FEE – AS PER THE 2020 HHS POVERTY INCOME GUIDLINES

PAY AMOUNT	NOMINAL FEE		25% PAY		50% PAY		75% PAY		100% PAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
FAMILY SIZE	0%	100%	101%	133%	134%	166%	167%	200%	201%	OVER
1	0%	12,760	12,761	16,971	16,972	21,182	21,183	25,520	25,521	OVER
2	0%	17,240	17,241	22,929	22,930	28,618	28,619	34,480	34,481	OVER
3	0%	21,720	21,721	28,888	28,889	36,055	36,056	43,440	43,441	OVER
4	0%	26,200	26,201	34,846	34,847	43,492	43,493	52,400	52,401	OVER
5	0%	30,680	30,681	40,804	40,805	50,929	50,930	61,360	61,361	OVER
6	0%	35,160	35,161	46,763	46,764	58,366	58,367	70,320	70,321	OVER

Special Population Information - Please circle Yes or No

Are you homeless? Y or N

Are you a migratory agricultural worker? Y or N

A migratory agricultural worker is an individual whose employment is in agriculture on a seasonal basis and who moves for their job.

Are you a seasonal agricultural worker? Y or N

A seasonal agricultural worker is an individual whose employment is in agriculture on a seasonal basis.

Do you live in public housing? Y or N

_____ _____

Patient/Guardian Signature Employee Signature

_____ _____

Date Date

110 E Mescalero Rd. Roswell, NM 88201 575.755.2272

CLIENT CONSENT AND
ACKNOWLEDGEMENT FORM
CONSENT TO EVALUATION AND SUBSEQUENT TREATMENT

I hereby consent to an evaluation and treatment by the clinical staff of La Casa Behavioral Health (LCBH) and understand that an explanation of treatment will be provided.

_____ _____
Patient's Signature or Printed Name of Minor Date

_____ _____
Patient/Legal Guardian's Signature Date

_____ _____
Staff Signature Date

STATEMENT OF FINANCIAL RESPONSIBILITY

By signing where indicated below, I agree to assume responsibility for payment of all costs, charges and fees to LCBH for services, medications, supplies and other items provided by LCCBHS, which are not otherwise paid by third party payer programs in which I am enrolled, including, without limitation, co-pays and deductibles. I am also aware that insurance claims not paid in 90 days will become my responsibility. I authorize any third party to pay directly and solely to LCCBHS any and all benefits due to me for services or items provided by LCCBHS. I acknowledge that failure to provide LCCBHS with the information necessary to bill any applicable third party payer will result in my being designated as financially responsible and all fees for services provided by LCCBHS shall be due in full at time of service.

I further grant LCCBHS permission to release/disclose any and all health records including alcohol and substance abuse records covered under 42 CFR, Part 2 necessary for purposes of registration, determining eligibility, for coordination of care, and billing my insurance company or other third party payment program in which I am enrolled, and release LCCBHS and any related entities, employees and Directors from any and all liability related to or arising from any such release or disclosure. The information used for the above purposes will be kept strictly confidential in accordance with all federal and state confidentiality laws. I understand that I may revoke this consent at any time; however, if I revoke my signed consent, I may no longer be eligible for coverage by my insurance company, or other third-party payment program.

_____ _____
Patient/Legal Guardian's Signature Date

Acknowledgment of Receipt

By signing below, I acknowledge that I have received and had the opportunity to discuss with my provider, the following documents:
1) LCCBHS Notice of Privacy Practices; 2) LCCBHS policy/procedure on Reporting of Abuse, Neglect and Exploitation; 3) LCCBHS Grievance Procedure; 4) LCCBHS Notice on Advanced Directives; and 5) Consumer Rights and Responsibilities.

_____ _____
Patient/Legal Guardian's Signature Date

Collection of Fees for Services Provided

Although La Casa Behavioral Health is a non-profit organization, we cannot provide free services to you. LCCBHS charges clients for all services that we provide. LCCBHS does offer financial options to you and your family.

Client Financial Options and Responsibilities

LCCBHS will bill third parties for services. You are responsible for your co-pay and other charges your insurance company requires you to pay. This would include co-insurance and deductibles. If we do not take your insurance or your visit is not a covered benefit, you will be responsible for payment.

New Mexico Medicaid plans:

- We accept all Medicaid plans
- You will be responsible for payment of services that are not covered by your Medicaid plan.

Medicare:

o We accept most New Mexico Medicare plans, as well as standard Medicare.

If you have no insurance and are 18 years or older you may be eligible for coverage from Falling Colors.

Private Pay

If you have no insurance or other coverage and are not eligible for coverage from Falling Colors, you may be eligible for a discount. Eligibility for the sliding fee scale discount is based on family size and total household income.

To access this benefit, you must provide proof of income. Any one of the following is acceptable as proof of income:

- Paycheck Stub/Social Security Check Stub
- Most Recent W-2 Tax form (Gross Income)
- Most Recent Tax Return (Gross Income)
- Letter from employer stating annual income
- Statement from ISD stating income and level of support
- Letter from responsible party providing Room and Board
- A Self Declaration for if zero household income (site administrator approval required)

We cannot put you on the sliding fee scale discount until we receive this documentation.

It is your responsibility to provide documentation and to update the information at least annually. Once family size and family income have been reported, the sliding fee scale will be used to determine the amount you owe.

RESPONDING TO YOUR NEEDS AND CONCERNS

All individuals interacting with La Casa Behavioral Health (LCCBHS) are treated with dignity, care, and respect. LCCBHS recognizes and observes the rights of clients/patients, families/guardians, and residents or visitors to provide compliments or grievances about conditions, treatments, or actions with which they are satisfied or dissatisfied. LCCBHS also recognizes that compliments and grievances serve as a source of information for validating and improving processes. We are focused on continually improving patient safety and quality of care.

If you would like to share a compliment, grievance, quality, or safety concern related to your care, services, or safety, please follow these steps:

Step 1: If you have a concern, please feel free to discuss it with the Site Administrator. Should you feel your concern has not been adequately addressed, please contact the LCCBHS Quality Management Department at:

Mail: La Casa Health Quality Management Department; 1515 W. Fir Street Portales, NM 88130

Phone: 1-575 — 356 - 6695

Step 2: If a satisfactory solution is not reached, you may utilize the LCCBHS Grievance Procedure as follows:

a) Discuss your grievance with the Site Administrator.

B) The Administrator will document the details of the grievance and witnesses (if any) will be noted.

c) Within ten (10) working days the Administrator will conduct an investigation on the grievance resulting in resolution decision.

d)Within five (5) working days of the completion of the investigation you will be notified of the resolution decision.

e) If the resolution decision is not satisfactory to you, you may request a review by a Grievance Committee within thirty (30) working days.

f) The Grievance Committee will review the case and give a final written decision to you and the Administrator. The decision is final and binding.

Advance Directives

In New Mexico, the Uniform Health-Care Decisions Act enables an individual to prepare an Advance Health-Care Directive, which is a written document that lets you give instructions about your own health care and/or name someone else (an agent) to make health care decisions for you if you become unable to make your own decisions. You have to be 18 or older to create an advance directive.

The Mental Health Care Treatment Decisions Act is the New Mexico law that allows written instructions for psychiatric treatment if you are unable to make or communicate your instructions. In New Mexico, "an advance directive for mental health treatment" is called a PAD or Psychiatric Advance Directive.

These documents are called Advance Directives because they are filled out by you and signed in advance so that in the future, your doctor and other health care providers know what your wishes are concerning medical or psychiatric treatment. Advance directives only take effect when you can no longer make your own health care decisions. As long as you are able to make your own decisions and give informed consent for your own care, your health care providers will rely on YOU and NOT your advance directives.

Before making this decision or writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends, and other appropriate people such as someone at your church or your lawyer.

ADVANCE DIRECTIVE IS OPTIONAL It is entirely up to you whether you want to prepare an Advance Directive, but if questions arise about the kind of medical or psychiatric treatment that you want or do not want, they will help solve these important issues. If you have not completed an Advanced Directive or told your doctor whom you want to make your health care decisions, New Mexico law allows these people, in the following order, to make your health care decisions (if these people are reasonably available: spouse, significant other, adult child, parent, adult brother or sister, grandparent, close friend.

New Mexico does not require you to fill out a specific Advance Directive form, you may write out your wishes. However, it does requires three things: 1) you must sign the Advanced Directive, 2) a PAD must be witnessed and if you wish, have it notarized, and 3) if you appoint an agent have the agent sign that he or she is accepting the appointment. That may be done on a separate piece of paper, but it may be helpful to have the acceptance a part of your Advanced Directive.

We have some samples available of Advanced Directive forms. If you are interested, please ask your therapist or CCSS worker for one. You have the right to revoke (cancel) or replace an Advanced Directive at any time. If you complete an Advanced Directive, give copies of the signed form to your health care providers and institutions, any health care agents you name, and your family and friends.

Any complaints concerning noncompliance with Advance Directive requirements may be directed to the La Casa Behavioral Health Quality Management Department, and /or the state survey and certification agency, the New Mexico Department of Health.

Consumer Rights and Responsibilities

La Casa Behavioral Health (LCCBHS) believes consumers or their legal guardians have the right to:

1. Be treated fairly, with dignity, and with respect for their right to privacy.
2. To receive all health care services in a caring, respectful, non-judgmental manner. If an individual is disoriented or lacks capacity to understand rights at the time of entry the client is informed again when the client is able to understand.
3. For those with communication-related disabilities receive any information in a format that meets your needs.
4. Get services in a way that respects your culture, including having an interpreter if you do not speak English.
5. Take part in making all health care decisions. This includes making treatment plans. You also have the right to refuse treatment. Involvement in your treatment is collaborative that you and your providers are actively engaged in.
6. Decide on treatment after being informed of your options and to give informed consent for said treatment.
7. Choose someone to help with care choices.
8. Make a complaint about your care or decisions about your care you are receiving without worrying about retaliation. You also have the right to access protective and advocacy services. LCCBHS staff will make referrals for individuals determined to need such services.
9. Make wishes known through advance directives, a legal document allowing you to direct your care if you cannot make or communicate decisions about your care or choose people you do or do not want to make choices on your behalf if you are ill.
11. Have access to medical records based on federal and New Mexico laws and rules, and to restrict access to the records based on those laws and rules including the right to request amendments to your record and obtain information about disclosures of chart information.
12. Get information about LCCBHS:
    - Its services and information about the person who has the primary responsibility for your care.
    - How to access services
    - Other information to help with your LCCBHS health care needs

12. Be free from unlawful restraint or seclusion, neglect, exploitation and verbal, mental, physical, and sexual abuse based on New Mexico and Federal law. LCCBHS reports allegations, observations and suspected cases of neglect, exploitation, and abuse to appropriate authorities.

13. You have a right to request an external consultation about your case. La Casa does not assume the financial responsibility for this.

14. You have a right to request an internal review of your case.

15. You have a right to refuse care, treatment, or services however, LCCBHS may decide to terminate services upon reasonable notice or to seek other alternatives, including legal options.

Consumer Responsibilities

Every consumer of LCCBHS or their legal guardian has the responsibility to:

1. To treat service providers with dignity and respect.

2. Provide, when able, clear information that LCCBHS providers need to serve you.

3. Understand your health issues and take part in planning treatment goals.

4. Follow the plans for care that you have agreed on.

5. Let provider know if changes to your care are needed.

6. To notify provider if medications change by another practitioner. To receive a medication refill, call 1 week prior to running out and expect up to 3 business days after request is made.

7. Make sure LCCBHS has your current contact information so we can reach you if necessary.

8. To provide a safe environment for care to be provided when such care is being provided in your home.

9. To attend appointments sober.

10. No weapons are allowed on the premises.

11. Keep, change, or cancel appointments instead of not showing up.

Notice of LCCBHS Policies and Procedures on Reporting of Abuse, Neglect and Exploitation

THIS NOTICE DESCRIBES HOW LCCBHS REPORTS ABUSE, NEGLECT OR EXPLOITATION OF ITS CONSUMERS AND HOW YOU CAN REPORT SUSPECTED ABUSE, NEGLECT AND EXPLOITATION.

Protection Against Abuse, Neglect and Misappropriation of Property It is the policy of La Casa Behavioral Health to prohibit the use of physical, verbal, sexual or psychological abuse, neglect, and exploitation. To protect the rights of consumers La Casa Behavioral Health s complies with state laws, regulations, and guidelines on ensuring safety and the reporting of abuse, neglect, exploitation, and misappropriation of property.

Purpose of Notice

This notice describes how LCCBHS reports abuse, neglect, exploitation, and misappropriation of property of is consumers as required by New Mexico State Law.

Our duties at all La Casa Licensed Health Care Facilities and Community Based Services Providers are required by law to:

- Report all incidents of suspected abuse, neglect, and misappropriation of property immediately to Adult Protective Services or Child Protective Services' Statewide Central Intake (SCI).
- Incidents of suspected abuse, neglect and exploitation which involve a La Casa Licensed Health Care Facility Services site are to be reported to the Department of Health's Division of Health Improvement (DOH/DHI) within 24 hours of knowledge of the incident and documented utilizing the Department of Health's Incident Report Form.
- In addition to the above listed practices, all Community Based Service Providers must complete the following within 24 hours or the following business day:

    a. Notify the consumer's case manager, if one is assigned, that an incident has occurred and has been reported to DOH/DHI
    b. Notify the parent(s) or legal guardian (s) of minor consumers of any reportable incidents, unless the parent(s) or legal guardian(s) are suspected of the alleged abuse, neglect, or exploitation
    c. If LCCBHS is not the responsible provider of the consumers, the site must notify the responsible provider that an incident has occurred and has been reported
- If you wish to report abuse, neglect, or exploitation, you may contact the DOH/DHI directly, or you may access the LCCBHS reporting process.
- Reports made directly to the DOH/DHI can be made by telephone, written correspondence or through other forms of communication by utilizing the DOH/DHI Incident Report form. Access to the DOH/DHI Incident Report form and instructions for its completion are available at the division's website, http://dhi.health.state.nm.us or may be obtained by calling the Department's toll free number at (800) 445-6242.
- To make a report to DOH/DHI through LCCBHS please contact the administrator of the LCCBHS site at which you receive care or services or contact the La Casa Family Health Corporate Compliance Officer at (575) 356-6695.

Questions? If you have any questions about this Notice or need additional information, please contact our Corporate Compliance Officer at (575) 356-6695

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.

Questions? If you have questions about this Notice or need additional information. please contact our Corporate Compliance Officer at (575) 356-6695.

Protection of Medical Information We understand that your medical information is personal, and we are committed to protecting your medical information. La Casa Behavioral Health ("LCCBHS") creates records of the care and services provided to you. We need these records to provide you with quality care and services and to comply with certain legal requirements.

Purpose of Notice This Notice describes how we may use and disclose your medical information to can't' out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your legal rights to access and control your medical information.

Who will follow this Notice? This Notice describes the privacy practices of LCCBHS. its clinics and other programs, as well as its affiliated health care professionals. We will share information with each other as necessary to carry out our respective treatment obligations, payment activities and health care operations.

Your Rights Although the records containing your medical information are the physical property of LCCBHS, the information belongs to you. By law you have the right to:

- Inspect and obtain a copy of your medical information. Generally, we will respond to your request within 30 days but, under certain circumstances, we may deny your request.
- Request a restriction on certain uses and disclosures of your medical information; however, we are not required to agree to a requested restriction.
- Request that we communicate with you by using alternative means or at an alternative location
- Request an amendment of your medical information, if you believe it is inaccurate; however, we may deny your request for amendment if we believe your medical information is correct
- Request an accounting of certain disclosures we have made, if any, of your medical information
- Revoke any authorization you have provided to use or disclose your medical information except to the extent that action has already been taken in reliance on such authorization.
- Obtain a paper copy of this Notice upon request.

You can exercise any of these rights by speaking with the administrator of the LCCBHS site at which you received care or services, or by contacting the LCCBHS Corporate Compliance Officer at (575) 345-6695.

How LCCBHS May Use and Disclose Your Medical Information

The following are examples of the types of uses and disclosures of your medical information that are permitted:

Treatment. We may use and disclose your medical information to provide, coordinate or manage your health care and any related services. For example, we may disclose your medical information to the doctors or technicians that care for you, even if the doctors or technicians are not affiliated with LCCBHS

Payment. Your medical information may be disclosed, as needed, to obtain payment from your insurance company or other person/party responsible for payment for services we provide to you. For example, we may disclose your medical information to your health plan to determine your eligibility or coverage for insurance benefits.

Health Care Operations. We may use or disclose your medical information for our internal operations, which include activities necessary to operate the LCCBHS sites or programs from which you receive services. For example, we may use your medical information for quality improvement services to evaluate the care or other services provided to you. We may also use your medical information to evaluate the skills and qualifications of our health care providers, or to resolve grievances within our organization.

Appointment Reminders and Treatment Alternatives. We may use and disclose your medical information to provide a reminder to you about an appointment you have with us for treatment or medical care. We may also use or disclose your medical information to tell you about or recommend possible treatment options or alternatives or inform you of other health-related benefits and services, that may be of interest to you.

Other Permitted Uses and Disclosures We may use and/or disclose your medical information in a number of circumstances in which it is not required that we obtain your consent or authorization, or provide you with an opportunity to agree or object

Those circumstances include:

- Unless you object, we may disclose your medical information to a family member, relative, close personal friend or other person that you identify
- We may be required by law to disclose your medical information. We will make your medical information available to you and the Secretary of the Department of Health and Human Services. We may disclose your medical information to a public health agency to help prevent or control disease, injury, or disability. This may include disclosing your medical information to report certain diseases, death, abuse, neglect or domestic violence or reporting information to the Food and Drug Administration, if you experience an adverse reaction from any of the drugs, supplies or equipment that we use.
- We may disclose your medical information to government agencies so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

- We may disclose your medical information as authorized by law to comply with workers' compensation laws.
- We may disclose your medical information in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request, or other lawful process.
- We may disclose your medical information to law enforcement officials to report or prevent a crime, locate, or identify a suspect. fugitive or material witless or assist a victim of a clime.
- We may use or disclose medical information for research purposes when the research received approval of an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your medical information.
- If you are a member of the armed forces, we may disclose your medical information as required by military command authorities or to evaluate your eligibility for veteran's benefits. for conducting national security and intelligence activities. including providing protective services to the President or other persons provided protective services under Federal law.
- We may disclose your medical information to coroners. medical examiners and funeral directors so that they can carry out their duties or for purposes of identification or determining cause of death.
- We may disclose your medical information to people involved with obtaining, storing, or transplanting organs, eyes, or tissue of cadavers for donation purposes.
- We may use or disclose your medical information to prevent or avert a serious threat to your health or safety, or the health or safety of other persons.
- We may disclose your medical information to a health oversight agency that is authorized by law' to oversee our operations.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your medical information to the law enforcement official or correctional institution. This disclosure is required for the institution to provide health care to you, to protect the health and safety of others, or to protect the health and safety of law enforcement personnel or correctional facility staff.

- We may share your medical information with third party "business associates" that perform various services for us. For example. we may disclose your medical information to third parties to provide billing or copying services. To protect your medical information, however, we require our business associate to safeguard your medical information

Other Uses and Disclosures of Medical Information

Other uses and disclosures of your medical 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 medical information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your medical 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 or services that we have provided to you.

New Mexico Law In the event that New Mexico law requires us to give more protection to your medical information than stated in this Notice or required by Federal law, we will provide that additional protection. For example, we will comply with state law confidentiality provisions relating to communicable diseases, such as HEY and AIDS. We will also comply with additional state law confidentiality protections relating to treatment for behavioral health and substance abuse. Those laws generally require that we obtain your consent before we disclose your information related to behavioral health or substance abuse, subject to certain exceptions permitted by law.

If you apply for and receive substance abuse services from us, Federal law' (42 CFR Part 2) requires that we obtain your written consent before we may disclose information that would identify you as a substance abuser or a patient for substance abuse services. There are exceptions to this general requirement. We may disclose such information to our workforce as needed to coordinate your care, to agencies or individuals who help us carry' out or services to you; when the disclosure is allowed by a court order: or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluations. Federal law does not protect any information about a crime committed by a patient either at the program or against any person who works for a program or about any threat to commit such a crime. Federal law does not protect any information about suspected child abuse or neglect form being reported under State law to appropriate State or local authorities.

Changes to this Notice We reserve the right to change our privacy practices and/or this Notice. If we revise this Notice, the revised Notice will be effective for all medical information we maintain, and a revised copy will be available at every La Casa site.

Complaints If you believe your privacy rights have been violated, you may file a written compliant with our Corporate Compliance Officer or the Secretary of the Department of Health and Human Services. You may call us at the phone numbers listed at the top of this Notice. We will not retaliate against you for filing a complaint.

FY 23/24 ***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	35	35	15
Graduation Cap & Gown			100
TOTAL Tuition & Fees	$3199 to $3273	$3199 to $3273	$2039 to $2069
MEAL PLAN	$1735	$1735	$1005

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

HOUSING @ Sierra Vista Village
~ $425/mo with 12 month lease = ~$5100 for the year (+ $200 deposit)

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

TOTAL Cost for the 3 Semesters for NM In-District Student (Tuition, Fees, Meals, Books, Housing, Supplies) = approximately $19,315

FY 23/24 ***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	35	35	15
Graduation Cap/Gown			100
TOTAL Tuition & Fees	$5459 to $5533	$5459 to $5533	$3439 to 3469
MEAL PLAN	$1735	$1735	$1005

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

HOUSING @ Sierra Vista Village
~ $425/mo with 12 month lease = ~$5100 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 $25,235

FY 23/24 ***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	35	35	15
Graduation Cap & Gown			100
TOTAL Tuition & Fees	$3297 to 3341	$3297 to 3341	$2109 to $2139
MEAL PLAN	$1735	$1735	$1005

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

HOUSING @ Sierra Vista Village
~ $425/mo with 12 month lease = ~$5100 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 $19,700

The Special Services Program at Eastern New Mexico University-Roswell (ENMU-R) is an 11-month, 50-credit-hour, occupational training program that leads students to a Certificate in Occupational Training (COT).

The nature of the Special Services program is unique in that we offer students with disabilities the opportunity to build their vocational skill set. We provide specialized certificate programs in Animal Healthcare, Child Care, Food Services, Office Skills, and Stocking & Merchandising. Vocational training emphasizes hands-on instruction, including 12-20 hours per week of on campus, lab, and off-campus practicum experiences. The technical skills taught in each career field prepare students for entry-level competitive employment in that discipline.

In addition to vocational training, the Special Services Program values and appreciates the importance of our students learning basic life skills. Students are simultaneously enrolled in core classes. These classes consist of Independent Living, Life Skills, Adaptive Physical Education, Job Skills, and Conflict Management. These courses teach students how to manage time, budget money, develop positive social skills, handle conflicts in appropriate manners, understand workplace ethics, prepare for job interviews, and how to live healthy, functional, and meaningful lives. All of these skills, in addition to all the other skills we teach, are important components in becoming successful employees and members of society.

Finally, students have the opportunity to return for a "second year'·. During a student's second year, he or she will study in a different vocational area; enhancing their ability to become employed post-completion. Second-year students continue to participate in the core classes, but at an advanced level, and have the option to move from our on-campus dormitories into our on-campus apartment-style facilities.

Our program gives students a supervised introduction to independence. Each student is monitored to ensure continued success, utilizing a structured and individualized plan, for each to gain self-reliance in a nurturing college setting.