Get involved!

The Transitional Coach School Grant Access Center Program provides an in-class and school-based blended behavioral and motivational support system designed to promote student success.
PROGRAM REGISTRATION FORM

Child’s Last Name: ____________________ First Name: ____________ Middle Initial: ___

Date of Birth: _________/_______/________

Child’s School Name: ____________________ Child’s Grade Level: ___

Child’s Home Street Address: ________________________________________________

City: _____________ State: ____________ ZIP Code: ______________

Child’s Gender at Birth: ☐ Male ☐ Female

Guardian’s Last Name: ____________________ First Name: _______________________

Phone Number: _______-_____________-_____________

Guardian’s Email Address: ____________________ Child’s Primary Care Doctor: _______________________

A. Does your child have a Medicaid Plan? Yes ☐ No ☐ Medicaid ID #: _______________________

Health Plan Name: ________________________________________________________________

B. Does your child have a Private Health Plan? Yes ☐ No ☐ ID #: _______________________

Health Plan Name: ________________________________________________________________

Legal Guardian Signature: __________________________ Date: _____/_______/________

I consent to my child’s participation in the Transitional Coach Program (Program). I understand the Program is a state and federally supported behavioral wellness school-based initiative. I understand the Program is not a department, committee, authority, board, or business entity of the school district. I consent to the Program’s access to my child’s student record during the time of my child’s participation in the Program. I understand that the Medicaid program and other health insurance companies (subsidizing agencies) may subsidize my child’s participation in the Program. In addition, I agree to allow the program to request reimbursement for my child’s participation from subsidizing agencies. I understand that I may access the Program’s Patient Bill of Rights at: https://www.aapsonline.org/patients/billrts.htm or request a copy from the Program’s Transitional Coach. I consent to the Program supplementing any behavioral wellness services currently received by my child. I understand any behavioral wellness program could cause emotional or physical responses. I agree to indemnify, defend, and hold harmless the Program, its agents, the local public school board, officers, vendors, partners, and employees from and again all liabilities, claims, losses, lawsuits, judgments, and/or expenses including, but not limited to, attorney fees arising either directly or indirectly out of the participation in the Program.

Confidentiality Notice: Anything you or your child informs us of will not be shared unless required by law. Information about your child may be discussed with other school personnel involved in your child’s academic or behavioral success. Information regarding your child’s participation with non-program professionals will not be shared or released with anyone without your written permission in the form of a formal letter and signed. Federal law and regulations do not protect any information about suspected child abuse or neglect, and we must report it to appropriate state or local authorities. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 42 U.S.C. § 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Please contact the Program’s Transitional Coach located at your child’s home school with any questions.