HEARING AND VISION SCREENING

PARENT PACKET

01/2023

Dear Parent/Guardian:

Hearing and vision screening is required by State of Illinois law for all children who attend a Preschool or/Daycare, unless a child has been seen by an optometrist or ophthalmologist within the last 12 months and has a written report on file at the school. Please see the bottom of this letter for the State of Illinois' statement on screening services.

The attached Hearing and Vision Screening Consent Form gives the Tazewell County Health Department permission to provide hearing and vision screenings for your child, and to report the screening results to the child's school/daycare. (It also allows the Health Department to bill Medicaid ONLY for screening services provided to children covered by Medicaid.) Please fill in the yellow areas on the Consent Form, so that we may provide this valuable service for your child.

Thank you in advance for your cooperation.

Sincerely,

Angie Phillips, MSN RN, CLC

Angie Phillips, MSN RN, CLC
Clinical Services Director
Tazewell County Health Department

410 ILCS 205/Child Vision and Hearing Test Act requires that children in specified age groups receive vision and hearing screening. Public Act 093-0504 requires that a child's parent or guardian be notified in writing before vision screening is done. "Vision screening is not a substitute for a complete eye and vision examination by an eye doctor. Your child is not required to undergo this vision screening if an optometrist or ophthalmologist has completed and signed a report form indicating that an examination has been administered within the previous 12 months AND the evaluation is on file with the school."

Hearing and Vision Checklist for Parents/Guardians

- [ ] Read through hearing and vision packet

- [ ] Fill out all required fields on the consent form and return to the school by: 09/06/2024

(We CANNOT provide screening services for a child unless the consent form is completed.)

- [ ] Practice pre-screening worksheet with child prior to screening date *(Included in packet)*

Screening Date/Time:

09/12/2024

Re-Screen Date/Time:
(If needed)

09/26/2024

If you have any questions, please reach out to your school/daycare provider

Thank you in advance

Tazewell County Health Department
Established 1970

01/2023

TAZEWELL COUNTY HEALTH DEPARTMENT
HEARING AND VISION SCREENING CONSENT FORM

Child's Last Name:_____ First Name:_____ Middle Initial:_____

Street Address/City/ZIP: _____

Date of Birth:_____/_____/_____ M_____ F_____ Phone Number: _____

NAME OF SCHOOL: _____

Notice of Privacy Policy: (Please Initial)
_____I acknowledge receipt of Tazewell County Health Department's Notice of Privacy Policy.

Authorization to Release Information/Financial Responsibility: (Please Initial)
_____ I authorize the release of any medical information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services provided to me by Tazewell County Health Department. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

_____ I authorize Tazewell County Health Department to release hearing and vision screening information to my (child's) school upon request. I understand that I have the right to revoke this authorization by giving written notice to Tazewell County Health Department. I understand that I cannot revoke authorization for information already released in reliance on an Authorization that I have signed. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law. I understand that the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

_____ I authorize Tazewell County Health Department to release immunization data, hemoglobin results, and blood lead level results to my (child's) school district upon request.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

Consent to Provide Hearing and Vision Screening Services:
_____I authorize Tazewell County Health Department to provide hearing and vision screening services as deemed necessary for the care of the client named above. I certify that I am the patient, parent or legal guardian of the patient. I have read the information provided about the services to be provided. I have had the opportunity to ask questions that have been answered to my satisfaction. I understand that this record will be maintained by the Tazewell County Health Department.
I understand I have the right to revoke this authorization by giving written notice to Tazewell County Health Department. This authorization is in effect for one year from the date below.

Signature:_____ Printed Name of Signee:_____
(Parent or Legal Guardian)
Date:_____

If client is covered by a State of Illinois medical card (Medicaid or other third-party Medicaid provider), please provide the client's medical card recipient number (Member ID number)
_____

JOINT NOTICE OF PRIVACY PRACTICES
Tazewell County Health Department

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

The Tazewell County Health Department (TCHD) works with Dr. Sarah Koscica, Dr. Diane Krall and University College of Medicine at Peoria (UICOM), in providing services to you. Dr. Koscica is TCHD's Medical Advisor, Dr. Krall is TCHD's Sexually Transmitted Disease Program doctor, and UICOM oversees TCHD's Tuberculosis program. Dr. Koscica, Dr. Krall and the physicians at UICOM are not part of TCHD's workforce. The health department and its employees and associates will follow this Joint Notice of Privacy Practices in providing services to you.

TCHD creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. The uses and disclosures described in this Notice apply to TCHD, including the doctors who are part of this Joint Notice of Privacy Practices while they are delivering services on behalf of the health department. This Joint Notice does not apply to these doctors when they deliver services on their own behalf.

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

This is a list of some of the types of uses and disclosures of Protected Health Information that may occur:

Treatment: We will use your health information for treatment. For example, we may use your child's record to determine what other immunizations or shots your child may need. We may also exchange information about your child's record with your child's doctor. We may also use your information to contact you to tell you about other health services that may help you. With your permission, we may give information about you to a friend or family member involved in your care.

Payment: We use your information to obtain payment for the services that we provide. For example, we send your information to Medicaid/Medicare or private insurance to obtain payment for our services

Health Care Operations: We use your information for our operations. For example, we may use your information to measure the quality of our services. We may use your information to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your information as required or authorized by law. For example, the next two requirements are common.

Public Health: We may report your information as required to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may give your information to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give INFORMATION to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

The following requirements for use and disclosure of protected health information are not common, but could apply to your information:

Judicial and Administrative proceedings: We may use and disclose your information in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your information by the party seeking the information.

Law Enforcement: We may use and disclose your information in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose information to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Immunization: we may release information regarding immunizations to a school or other facility with your permission

Avert a Serious Threat to Health or Safety: We may use or disclose your information to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose information to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may disclose information to a coroner or medical examiner in some situations. For example, information may be needed to identify a deceased person or determine a cause of death. Funeral directors may need information to carry out their duties.

Armed Forces: We may disclose the information of Armed Forces personnel to the military for proper execution of a military mission. We may also disclose information to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may disclose information to maintain the safety of the President or other protected officials. We may disclose information for the conduct of national intelligence activities.

Correctional institutions and custodial situations: We may disclose information to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclose information for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising/Marketing: Ordinarily, we do not use individual information to do fundraising or marketing. You have the right to opt out of such communication.

Sale of PHI: We will not sell your PHI without your permission.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your information. In order for us to release information about mental health treatment, genetic information, AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal privacy laws relating to your information. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your information is used for purposes of treatment, payment and health care operations. We are not required to agree to your request. We will agree to your restriction if you request that we not bill your health plan and you have paid for you services in full in advance.

Communications: You have a right to receive confidential communications about your information. For example, you may request that we only call you at home. If your request is reasonable, we will accommodate it. We will email or text with your permission, however, this is an inherently insecure method of communication.

Inspect and Access: You have a right to inspect your information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options. You may copy your information in most situations. If you request a copy of your information, we may charge you a fee for making the copies and for mailing them to you, if you ask us to mail them.

Amendments of your Records: If you believe there is an error in your information, you have a right to request that we amend your information. We are not required to agree with your request to amend your information.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your information for purposes other than treatment, payment, and health care operations, or for release of information that you have authorized.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at the health department offices and on our website.

Breach: If there is a breach affecting your unsecured PHI, we will notify you.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with the health department by calling our Privacy Officer or a Nursing Program Director at (309)925-5511. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

We do not release information about people who are at TCHD for services. If someone calls or comes in and requests information about you, we will take a message without releasing any information and pass the message on to you.

Some public health services are delivered in a public setting. Incidental disclosure of protected health information may occur; however, we will minimize this disclosure as much as possible. If you have concerns about this, please notify a health department staff member.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website, or by stopping by our office to pick up a copy. Changes to the Notice apply to the health information we already have.

If we seek help from individuals or entities who are not part of this Notice in our treatment, payment, or health care operations activities, we will require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule.

EFFECTIVE DATE:
12/17/2019
21306 Illinois Route 9,
Tremont, IL 61568
309-925-5511

Prescreening HOTV Practice Sheet

In order for us to check your child's vision he/she must be able to play a matching game.

1. Cut the paper along the dotted lines.
2. Place Chart 1 with the four large letters in front of your child.
3. Point to a letter on Chart 2 and have your child touch the letter that looks the same on Chart 1. Start with the larger letters and movedownward to the smaller.
4. Play the game until your child responds correctly and consistently.

CHART 1

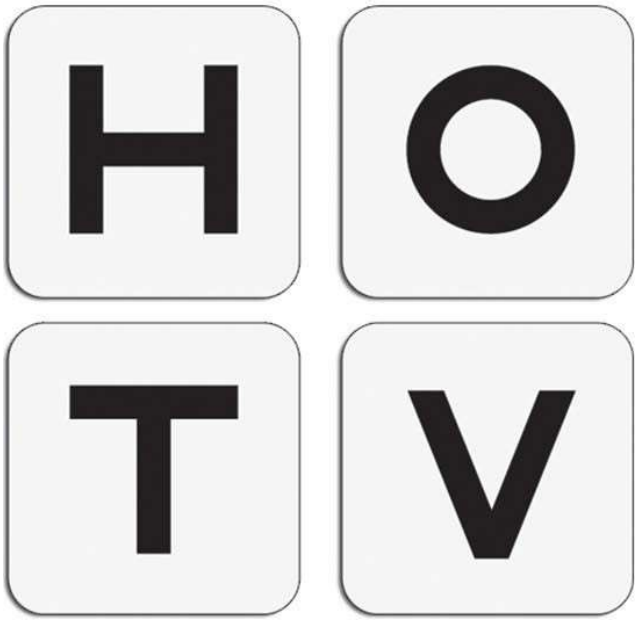

CHART 2