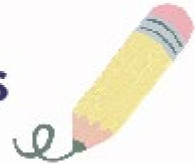
Chesapeake
HEALTH CARE

SCHOOL-BASED PROGRAMS OFFERED



COORDINATED COMMUNITY SUPPORTS GRANT PROGRAM

Through our partnership with Wicomico County Public Schools, Chesapeake Health Care (CHC) will host multiple therapeutic groups to assess and provide the services needed for students.

Additionally, CHC can assist in connecting students and families with services to include translators, community outreach workers, certified application counselors to assist with financial needs, peer support, resource coordinators, client navigators, and the full complement of medical, dental, pharmaceutical, and behavioral health services.

CHC will also provide several evidence-based trauma-informed programs for students.

MATCH-ADTC

For children ages 6 to 18 and grades 1-12 Designed to serve youth and families coping with anxiety, depression, trauma, or conduct problems.

THE STUDENT CHECKUP

For adolescents aged 12 and older. Designed to help adolescents adopt academic enabling behaviors, determine behavioral health needs, and assess those who suffer from substance use.

UP-C/UP-A

For children from 2nd grade through 12th grade, with UP-C applying to ages 7-12, and UP-A ages 12-18. Designed for treatment of anxiety disorders to reduce anxiety and the symptoms of social disorder.

To get started with services, please fill out and return a registration packet to your participating school or the CHC office at 1104 Healthway Dr. Salisbury, MD 21804. We will contact you to process information and set up a date and time for your child's group.

PROGRAM REGISTRATION FOR THE COORDINATED COMMUNITY SUPPORTS GRANT

1. Student Information

First Name: ____________________Middle Name:_____________Last Name: ____________________

Student Address

Street/Apt #: ____

City: ________________________________ State: _______________ Zip: ___________

Phone #: ___________________________________ Circle one: Home / Mobile

Student DOB: _____/______/______ Student SSN: ___________________

Race/Ethnicity

☐ African American/Black ☐ Asian or Pacific Islander ☐ Hispanic/Latin

☐ Middle Eastern or North African ☐ Multi-racial ☐ White ☐ Unknown/Prefer not to respond

Gender Identity

☐ Male ☐ Female ☐ Nonbinary ☐ Unknown/Prefer not to say.

School: ____ Grade: _________

IEP (Circle one): Yes / No

Interpreter needed (Circle one): Yes / No If yes, please specify language: ________________

Student Insurance Provider

Name of provider: ____

Insurance number: ____

Phone number: __________________________

2. Parent/Guardian Information

Parent/Guardian First Name: ____

Parent/Guardian Last name: ____

Parent Guardian Address (Skip if same as student's):

Street/Apt #: ____

City: ____________________________________ State: ______________ Zip: _________

Parent/Guardian Contact Information

Phone # (Home): _________________________Phone # (Mobile): ___________________

Phone # (Work): __________________________

3. Student Services Information

Involved in Wrap MD or any after school programs (Circle one): Yes / No

If yes which one: ____

Involved in mental health treatment (Circle one): Yes / No

If yes:

Primary therapist name: ____

Primary therapist agency: ____

What program(s) are you interested in?

☐ Circle of Security ☐ Parent Education Group ☐ The Student Checkup

☐ MATCH-ADTC ☐ UP-C/UP-A

Primary Behavioral Health reason(s) for Registration:

____

____

____

Risk Taking Behaviors (include History of Violence, Aggression, and Substance Abuse):

____

____

____

CONSENT FOR TRANSFER OF CONFIDENTIAL STUDENT INFORMATION TO CHESAPEAKE HEALTH CARE APPLICABLE TO THE COORDINATED COMMUNITY SUPPORTS PARTNERSHIPS GRANT

This form is completed by the parent/guardian for the purpose of allowing authorized persons, agents and employees in Wicomico County Public Schools to share with and receive information from the agency or person noted below. This exchange of information is intended to support the well-being, academic opportunity and success of the student enrolled in one or more of the following programs: UP-C/UP-A, MATCH-ADTC, Student Checkup, Circle of Security, and/or Parent Education Group.

Student's Legal Name: ____
Last Name First Name Middle Name

Student's Address: ____
P.O. Box Street City State Zip Code

Date of Birth: ______/______/________ Grade: ______ Social Security Number: _______________

Parent(s)/Guardian(s): ____
First Name Last Name

Agency and Person With Whom Confidential Information May Be Shared:

Chesapeake Health Care
Behavioral Health – Healthway Drive, Salisbury
1104 Healthway Drive
Salisbury, MD 21804
Tel: 410-219-1100

CHC can share information with the following in the Wicomico County Public Schools:

Principal
School social worker
School counselor
Assistant Principal
Student Advisor
Mental Health Coordinator
School psychologist

Manner for Release/Exchange of Information (Check all that apply.):
___Verbal communication/exchange ___Email communication/exchange

Reason for Request (Must be completed by agency/person requesting information):
After school groups provided by Chesapeake Health Care

Parent/Guardian:
I give my permission for authorized persons, agents, and employees in Wicomico County Public Schools to exchange with the therapist/agency identified herein updates, concerns, and celebrations about my

child, ___________________. I also give my approval for the therapist/agency identified herein to meet with and provide appropriate services to my child at the school after the school day ends as deemed appropriate by school administration.

____ ________________

Parent/Guardian Signature Date

******This completed form is valid through the final day of instruction for students 2024/2025 school year.*

Group Transportation Permission Slip

I, __________________________, give my permission for __________________________,
(Parent/Guardian's Name) (Child's Name)
to attend Chesapeake Health Care's (CHC) Behavioral Health Therapeutic Program. I understand that by signing this form, I give permission for my child to be transported by CHC staff to CHC's program location and/or from a Wicomico County Public School to an approved site and their home. I understand and acknowledge that participation in this activity involves inherent risks, including those associated with transportation by motor vehicle.

________ INITIAL I agree to indemnify and hold harmless Chesapeake Health Care, employees and volunteers, its governing board, and the individual members thereof, from any liability, lawsuit, cost, expense, or claim of any type whatsoever (including legal fees) for any harm, injury, or death arising out of participation in the above-mentioned activity.

________ INITIAL I acknowledge that my child must be at the pickup location between 5 to 10 minutes before the vehicle's scheduled arrival time. Drivers will wait no more than 3 minutes for a child. If the child is not present within that time, the driver must proceed with their route.

________ INITIAL I acknowledge that if my child is not present for a scheduled pickup more than twice, all transportation privileges will be suspended, and I will be responsible for transporting my child to and from the group.

________ INITIAL If I cannot be reached in an emergency, I hereby permit Chesapeake Health Care to call 911 and/or to contact a medical facility or medical provider selected by Chesapeake Health Care to provide medical treatment to the above identified child. I acknowledge that I will be responsible for all expenses arising in association for such treatment.

Please note that we are not able to leave the child at the house or bus stop location alone without a parent or guardian present. If we go to the home or stop and the parent/guardian is not present, your child will return to CHC's office, and you will be responsible for picking your child up ASAP. Because staff members would be required to stay with your child if this happens, all transportation privileges will be suspended, and you will be responsible for transporting your child to and from the group.

______________________________________ ________________________
Parent/Guardian Signature Date

In case of an emergency, I am providing the following contact information to be called for my child:

_______________________________________ ____________________________

Emergency Contact Name | Phone Number

_______________________________________ ____________________________

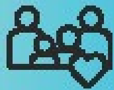
Parent/Guardian Signature | Date

Home Address for Transportation:

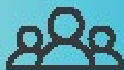
____

PARENT EDUCATION GROUP OF SCHOOL AGED CHILDREN

COMMUNICATING WITH KIDS AND TEENS & CIRCLE OF SECURITY



CHC will be hosting parents from the community for two groups, one addressing communication between parents, children and teens, as well as a group for parents of children between the ages of kindergarten and 3rd grade on attachment theory and needs.



These groups are open to parents of all students enrolled in Wicomico County Public Schools.

Call to register at the number below for the first group, more dates to follow! Light refreshments will be served.

GROUP LEARNING GOALS

Communicating with kids and teens
This group will address issues such as clear communication, effective parenting, setting boundaries, and more.

Circle of Security
This group is designed to address and intervene with caregivers in a household of children between the ages of kindergarten and 3rd grade and uses an attachment theory model to teach caregivers about their child's need for security and growth.

Contact Michelle Corbin at 410-219-5483 for further information and inquiries.