

ALL TEAMS

Cumberland/Perry Drug & Alcohol Counselor

Mr. C. Acker.....Liaison for High School

Teenline Counselor

Ms. C. Werner.....Liaison for High School

Social Worker

Mrs. A. Romano.....CVHS Teams



HIGH SCHOOL STUDENT ASSISTANCE TEAM MEMBERS

9th Grade SAP Team

Mrs. A. Miller..... Asst. Principal
Ms. W. Ellenberger..... Counselor
Mr. M. Ryan..... Counselor
Ms. S. Knerr..... Teacher
Mrs. J. Mealy..... Teacher
Dr. J. Coslett..... Psychologist
Mrs. M. Ferguson..... Secretary

10th Grade SAP Team

Mrs. C. Staton..... Asst. Principal
Mr. R. Martin..... Assoc. Principal
Ms. B. Maguire..... Counselor
Ms. E. Bashore..... Counselor
Mrs. N. Leitzel..... Teacher
Dr. J. Coslett..... Psychologist
Mrs. M. Ferguson..... Secretary

11th Grade SAP Team

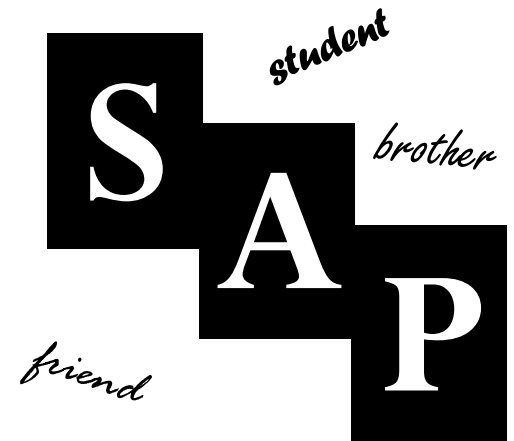
Dr. M. Jones..... Asst. Principal
Mrs. S. Weary..... Counselor
Mrs. K. Baldwin..... Counselor
Mrs. J. Whitehead..... Teacher
Ms. A. Polillo..... Teacher
Dr. J. Coslett..... Psychologist
Mrs. M. Ferguson..... Secretary

12th Grade SAP Team

Mrs. J. Croft..... Asst. Principal
Mrs. M. Nitchman..... Counselor
Mrs. K. Clements..... Counselor
Mrs. D. Rupp..... Teacher
Mr. D. Porter..... Teacher
Dr. J. Coslett..... Psychologist
Mrs. M. Ferguson..... Secretary

2020-2021
Cumberland Valley
High School

Are You Worried About Someone ?



....Student Assistance

Can Help

son

daughter

sister

STUDENT ASSISTANCE PROGRAM

WHAT IS THE STUDENT ASSISTANCE PROGRAM (SAP)?

In Pennsylvania, every middle, high school, and some elementary schools have a Student Assistance Program (SAP). A SAP Team is made up of school and community agency staff. The team is here to help you access school and community services. If your child is having trouble in or out of school, we can help, as there may be times when you just do not know how to help. That's okay; someone else may know how to help. Don't feel embarrassed or uncomfortable about asking for help. When extra help is needed, knowing how and where to find it can be overwhelming.

IS YOUR CHILD EXHIBITING ANY OF THESE BEHAVIORS?

- Withdrawing from family, friends and/or school
- Changing friends; no longer spending time with old friends
- Unexplained physical injuries
- Talking about suicide
- Depressed
- Defying authority, both at home and at school
- Acting aggressively
- Lying
- Needing money without an explanation
- Sudden drop in grades
- Experimenting with drugs or alcohol

ARE YOU CONCERNED ABOUT YOUR CHILD'S REACTION TO:

- Recent death of a loved one
- Divorce of parents
- Family relocation
- A relationship problem

HOW DOES MY CHILD BECOME INVOLVED IN THE PROGRAM?

Our team will help you find services and assistance within the school and, if needed, in the community. We do not diagnose, treat, or refer your child for treatment. Rather, we will provide you with information; **YOU** make the choices.

REMEMBER, YOU ARE PART OF OUR TEAM.

Our goal is to help your child succeed in school. Students come to the SAP team in different ways. Anyone can refer a student to SAP. Some students are referred by teachers and other school personnel. Any school staff member, a student's friend, or family member, can let the SAP team know that they are worried about someone. The students themselves can even go directly to the SAP team to ask for help. However, the SAP team will not become involved unless we receive *both* parent and student permission.

WHAT IF SOMEONE HAS ALREADY REFERRED MY CHILD TO SAP

First, know that your child was referred because someone is concerned about observable changes they are seeing in your child. Perhaps a teacher or friend has noticed changes in behavior and habits that you may or may not have noticed at home. Your observation of your child at home are important.

The SAP team will request that you sign a permission form for your child to become involved in the program. Once you sign, the SAP team will begin to work with your child and keep in touch with you. If you feel you need more information before making a decision, please let your SAP team know. If you do not sign the permission form, the SAP team will NOT become involved. Participation is voluntary.

WHAT HAPPENS AFTER I GIVE MY PERMISSION?

Together, you and the SAP team will develop a plan of action to help your child achieve success in school. The plan might include services and activities in school and/or services from a community agency. Either a SAP team member or agency liaison will keep in touch with you. We remain concerned and interested in your child.

CONTACTING YOUR SCHOOL'S SAP PROGRAM

If you feel that your child may need help, call your child's school and ask to speak with a Student Assistance team member or your child's guidance counselor. Someone will be there to help you.

PRIVACY

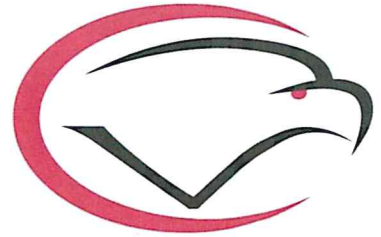
The Student Assistance Teams and the school will respect you and your child's privacy at all times.



Cumberland Valley School District

6746 Carlisle Pike, Mechanicsburg, PA 17055

Phone (717) 697-8261



Student Assistance Program

Permission Form

I give permission for my son/daughter: _____, grade: _____
to participate in the Student Assistance Program (S.A.P.) of the Cumberland Valley School District, as
explained to me by: _____.

Please return this form to: _____

I also give permission for him/her to meet with a TEENLINE MENTAL HEALTH COUNSELOR AND/OR
CUMBERLAND PERRY DRUG & ALCOHOL COUNSELOR.

I permit the Student Assistance Team to release relevant information from student's records for the purpose
of assessment. All Student Assistance information will be maintained in the strictest confidence. This
permission form is valid form **one year** from the date of signature.

Parent/Guardian Signature

Parent e-mail address

Parent home and/or cell phone

Student Signature

Date

***For additional information please visit the Cumberland Valley School District website at:**
www.cvschools.org → Student Services → Student Assistance Program

-or-

Please contact: Melissa Ferguson, SAP Coordinator
mferguson@cvschools.org –or- (717) 506-3632



**Student Assistance Program
Informed Consent for a Mental Health Assessment**

Your child has been referred to the Student Assistance Program (SAP) at school. SAP is a voluntary process. In the event that the SAP team feels your child could benefit from a mental health assessment, you will be contacted by a SAP team member, and one can be conducted by a Teenline counselor with your written permission. Upon completion of the assessment, the Teenline counselor will contact you to offer recommendations for you to consider. * You can also contact the Teenline counselor ahead of time with questions or concerns. The Teenline counselor *does not* provide ongoing counseling or mental health treatment. Teenline cannot assess students who are already receiving mental health services. **In order for the assessment to take place, Teenline needs your written permission below.**

The assessment is free of charge and will take place during the school day at your child’s school. The Teenline counselor will have access to your child’s school records to assist in the assessment. All student assistance information will be maintained in the strictest confidence. A written recommendation from the assessment will be provided to the school’s SAP team to be placed in their student SAP file. We are providing you with a *Notice of Privacy Practices* for your review. Your signature below also acknowledges you received this information. If you have any questions, please feel free to contact Teenline at 717-763-2345.

Thank you for your cooperation.

*According to Pennsylvania law, a person age of 14 or older has a right to decide how much information is shared and with whom after the assessment.

Parent/Guardian Permission Form

Student’s Name: _____ Grade: _____ Date of Birth: _____

Please circle: Yes or No A member of the school’s Student Assistance Program (SAP) has explained the SAP process to me and the purpose of the mental health assessment.

Yes or No My child is already receiving mental health services with a treatment provider such as a psychiatrist, therapist, counselor and/or mental health case manager.

_____ I give permission for my son/daughter to participate in a confidential assessment conducted by a Teenline counselor during school hours at my child’s school building. I understand that this assessment is conducted as part of the SAP process and a written recommendation will be shared with the SAP Team to be placed in your child’s SAP file. It will allow the SAP team to offer recommendations for in-school and out-of-school supports. This information will also be shared with me and my child.

_____ I do not give permission for my son/daughter to participate in a confidential assessment conducted by a Teenline counselor. I understand that should I change my mind, I can contact anyone on the SAP Team.

Parent/Guardian Signature: _____ Date: _____

Phone Number(s): _____

Penn State Health Privacy Notice

Effective Date: November 29, 2017

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.

If you have any questions about this Notice, please contact our Privacy Office at (717) 531-2081.

WHO WILL FOLLOW THIS NOTICE:

This Notice describes Penn State Health (PSH) practices and that of any health care professional authorized to enter information into your PSH chart; all departments and units of PSH; any member of a volunteer group we allow to help you while you are being cared for by PSH; all employees, staff, students, trainees, and other PSH personnel; and all of our on- and off-campus community, clinics, and doctors' offices.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at PSH. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by PSH, our on- and off-campus clinics, and doctors' offices. This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- *Make sure that medical information that identifies you is kept private;*
- *Provide this Notice of our legal duties and privacy practices with respect to medical information about you; and*
- *Follow the terms of the Notice that is currently in effect.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:*

For Treatment: We may use medical information about you to provide you with medical treatment or services. We

may disclose medical information about you to doctors, nurses, technicians, medical and other healthcare students, or other PSH personnel who are involved in taking care of you at PSH. For example, a doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at PSH may be billed to, and payment may be collected from you, a health plan, an insurance company, or a third party. For example, we may need to give your health plan information about surgery you received at PSH so that your health plan will pay us or reimburse you for the surgery.

For Health Care Operations: We may use and disclose medical information about you for PSH operations. These uses and disclosures are necessary to run PSH and to make sure that all of our patients receive quality care. For example, we may disclose information to doctors, nurses, technicians, medical and other healthcare students, and other PSH personnel for review and learning purposes.

Health Information Exchanges: We may use and disclose medical information about you electronically through Health Information Exchanges ("HIE"s) to ensure that your healthcare providers outside of PSH have access to your medical information regardless of where you receive care. In addition, PSH personnel may use HIEs to obtain information about care you received from healthcare providers outside of PSH when those providers share your medical information with an HIE. Having immediate access to your medical information through an HIE allows healthcare providers to improve the safety and quality of care they provide to you. Organizations that participate in HIEs may also use medical information for purposes other than treatment as allowable by law. Patients may opt-out of HIEs. PSH will

use reasonable efforts to limit the electronic sharing of medical information for patients who have opted-out. If you wish to opt-out, please request an opt-out form from PSH registration staff.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at PSH.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Business Associates: There are some services provided at PSH through agreements and arrangements with other organizations and individuals not employed by PSH. Examples include companies performing maintenance on medical equipment, and temporary personnel provided by agencies ("Associates"). We may disclose your medical information to these Associates so that they can provide necessary services. We require these associates to agree that they will protect the privacy of your medical information in the same manner that we do.

Fundraising Activities: We may use limited medical information about you to contact you in an effort to seek voluntary donations to support the charitable missions of PSH. We may also disclose limited information to Penn State (which helps PSH seek charitable donations) so that Penn State may contact you in raising money for PSH. If we use or disclose your medical information for fundraising activities, we will provide you the choice to opt-out of those activities. You may also choose to opt back in.

PSH Directory: We may include certain limited directory information about you in the hospital directory while you are a patient at the hospital. Directory information may include your name, location in the hospital, your general condition, and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy. However, you can tell us not to release any part or all of this directory information and we will follow your instructions.

Individuals Involved in Your Care: We may release medical information about you to a friend or family member who is involved in your medical care.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. The use and disclosure for research projects are subject to a special authorization process. This process evaluates a proposed research project and its use of medical information, determining that your medical information will be adequately protected. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project to help them look for patients with specific medical needs, so long as the medical information they review does not leave PSH.

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

SPECIAL SITUATIONS:

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose medical 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 they may be using.
- 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 medical information 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: In connection with a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We may use and disclose medical information in defending or asserting a lawsuit involving your treatment at PSH.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar law enforcement process.

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

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

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

We may disclose or release other certain types of your medical information but only with your consent, authorization or opportunity to object, unless we are required by law. Specifically, without your authorization, we are expressly prohibited from using or disclosing your medical information for marketing purposes. In addition, we may not sell your medical

information without your authorization. We may not use or disclose psychotherapy notes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of medical information, except psychotherapy notes. You must submit your request in writing to Health Information Management. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and obtain a copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by PSH will review your request and the denial. The person conducting the review will NOT be the person who denied your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to add to or refute the information. Your request must be made in writing and submitted to Health Information Management. In addition, you must provide a reason that supports your request. We may deny your request 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 add to or refute information that:

- *Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;*
- *Is not part of the medical information kept by or for PSH;*
- *Is not part of information which you would be permitted to inspect and obtain; or*
- *Is accurate and complete.*

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you to organizations or persons outside PSH. The list will not include disclosures we made to you, disclosures made for purposes of treatment, payment or our operations, or those authorized by you. To request this list or accounting

of disclosures, you must submit your request in writing to the Privacy Office. Your request must state a time period of disclosures to be included, up to six years prior to the date of your request. The first list you request within a twelve-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.

Right to Receive Notice of a Breach: We will notify you if any of your medical information has been breached.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request, except if you request that we not disclose your medical information to your health plan with respect to healthcare for which you have paid PSH out of pocket, in full. To request restrictions for disclosure to your health plan, you must make your request to registration staff at the time of service. To request all other restrictions, you must make your request in writing to the Privacy Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to ask that we send information to you to an alternate address or by alternate means. We must agree to your request so long as we can easily provide it in the format you requested.

Right to Get This Notice by E-Mail: You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of this Notice. (Please note: If you are interested in communicating with your PSH physician by e-mail, you should read "A Patient's Guide to Electronic Mail," available on our Web site, and at our care facilities.)

You may obtain a copy of this Notice at our Web site, <http://hmc.pennstatehealth.org/privacy>, or by writing to:

Privacy Office
P.O. Box 850, MC A150
Hershey, PA 17033

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice: We reserve

the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at PSH. The Notice will contain the effective date on the first page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with PSH or with the Secretary of the Department of Health and Human Services. There will be no retaliation from PSH for filing a complaint. To file a complaint with PSH, you must contact:

Privacy Office
P.O. Box 850, MC A150
Hershey, PA 17033
Phone: (717) 531-2081

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

*Pennsylvania Code requires your written authorization for release of protected health information outside of our hospital. Since that requirement pre-empts HIPAA, you will be asked to sign such an authorization when you register for an inpatient, outpatient, or emergency visit, allowing us to send information to your health insurance company. The statement is included in the consent for treatment and assignment of benefits forms.

Por favor solicite una copia en Español de este Aviso de Privacidad a su representante de admisiones de PSH.



PennState Health