

COLLABORATIVE WORKING AGREEMENT BETWEEN
GALENA PARK INDEPENDENT SCHOOL DISTRICT
AND
LEGACY COMMUNITY HEALTH SERVICES, INC.

This Collaborative Working Agreement (the "Agreement") is entered into by and between Legacy Community Health Services, Inc. ("Legacy") and Galena Park Independent School District ("Galena Park ISD") as of August 1, 2020 (the "Effective Date"). Legacy and GPISD are herein collectively referred to as the "Parties" and individually as a "Party".

I. RECITALS

WHEREAS, Galena Park ISD proposes to address certain healthcare needs of its students, student's siblings, and the children of Galena Park ISD staff members by contracting with Legacy to provide certain limited onsite health and behavioral healthcare services to augment Galena Park ISD's school health program.

WHEREAS, Legacy proposes to provide certain limited onsite health and behavioral healthcare services ("Services") to Galena Park ISD students and families as set forth in this Agreement.

WHEREAS, the Services under this Agreement will not be funded with any state grant funds described under Texas Education Code Chapter 38.

NOW THEREFORE, in consideration of the mutual covenants contained herein, the sufficiency of which is hereby acknowledged by the Parties, and intending to be legally bound hereby, the Parties hereto agree as follows.

II. PROJECT DESCRIPTION

Legacy will provide Services at Galena Park ISD's schools as listed on Exhibit A (the "Schools").

1. For the duration of the Term, as defined herein, Legacy and Galena Park ISD agree to collaborate as set forth in this Agreement.

2. Legacy agrees to provide certain health care service providers onsite at the Schools, as more fully described herein.

a) Legacy shall provide Services, as it reasonably determines to be appropriate and necessary, as more fully described herein, to help meet the health and behavioral health needs of Galena Park ISD's students, student's siblings, and the children of Galena Park ISD staff members. Legacy shall provide such Services through appropriately licensed professionals and para-professionals, as it deems appropriate and in accordance with community standards of care and applicable laws and regulations, and as approved by Galena Park ISD.

- b) Legacy shall develop and maintain policies and procedures for the provision of the Services at the Schools, subject to modification at the reasonable request of Galena Park ISD. Galena Park ISD shall designate and assign staff members to support student escorts to and from the designated area used by Legacy (the "Clinic Area"), as needed. Galena Park ISD shall advise Legacy, in advance in a timely manner, of the staff members it has assembled to assist with the escort of students to and from the Clinic Area.
- c) Legacy shall be responsible for the operation, management and staffing of the Services provided by Legacy at the Clinic Areas.
- d) Legacy shall be responsible for providing, at its sole expense, (i) all necessary, computer and data equipment necessary to efficiently perform the Services; (ii) suitable electronic medical record system, including, maintenance, system upgrades and backup work flows; (iii) appointment scheduler; (iv) patient portal; and (v) all necessary furniture and equipment to perform the Services.
- e) Legacy shall have the right to bill students, student's siblings, and the children of Galena Park ISD staff members for health care Services provided by Legacy's professional staff in accordance with Legacy's usual and customary fee schedule, provided that the student/student's sibling/child of Galena Park ISD staff member has consented to the provision of such Services prior to the Services being rendered. To the extent permitted by law, Galena Park ISD shall cooperate with Legacy to obtain health insurance information, if any, from any and all students and their parents or guardians who receive Services under this Agreement. The Parties expressly agree that Galena Park ISD has no financial liability for the Services that Legacy provides to the students, student's siblings, or child of Galena Park ISD staff members.
- f) Legacy shall maintain Patient health records and related information regarding the Services provided by Legacy and its personnel hereunder on its electronic health records system ("EHRS") for a period of no less than five (5) years, or for such longer periods as may be required by law. Upon the termination of this Agreement, Legacy shall keep or retain any such Patient records or information unless a patient specifically requests a different disposition of his or her records and Legacy can legally comply with such a request. Legacy shall be entitled to retain a copy of or, at Legacy's election, Galena Park ISD shall provide Legacy with reasonable access to Galena Park ISD records and information upon request, subject to all applicable law, rules and regulations as to confidentiality, if Legacy shall need the Galena Park ISD records for lawful purposes. Legacy represents and warrants that it will maintain all Patient records in accordance with applicable state and federal laws.

- g) If Galena Park ISD determines that the continued assignment of any Legacy personnel is not in the best interests of Galena Park ISD for any lawful reason, Galena Park ISD may request in writing that the individual be replaced in a reasonably timely manner. Legacy will remove that individual from Galena Park ISD's account and the Schools and replace that individual with another employee of suitable ability and qualifications.
 - h) In accordance with and subject to all applicable requirements under the Family Educational Rights and Privacy Act, 20 U.S.C. 1232g ("FERPA") which may prohibit Galena Park ISD from sharing student contact information in certain instances, Legacy shall have the right to contact students and parents or guardians to provide and improve parent, student and community awareness of Legacy through contacts, promotional events, print materials and otherwise to enhance the general awareness of the services offered by Legacy at the Schools. Such education and awareness shall be presented by means of direct mail promotional materials, internet, telephonically and other lawful and appropriate means customary to the provision of Services. Galena Park ISD agrees that Legacy shall have the right, upon review and prior written approval by Galena Park ISD, to use Galena Park ISD's name for the purpose of informing students and parents of the location of the Clinic Areas in all such promotions and education and awareness campaigns. And shall have the right, upon review and approval by Galena Park ISD, to use Galena Park ISD's name and logo to create one or more Galena Park ISD clinic webpages on Legacy's website. Galena Park ISD retains final authority to veto the use of its name and/or logo in any promotion, website, or campaign. Galena Park ISD shall provide student and parent contact information electronically as permitted by FERPA, as may be reasonably requested from time to time by Legacy, in order to facilitate such contact.
 - i) Legacy shall be responsible for providing biohazard waste removal services for all Clinic Areas.
 - j) Legacy shall be responsible for the operation, management and staffing of the Services provided by Legacy at the Clinic Areas.
 - k) At the conclusion of this Agreement, whether as the result of early termination, expiration, or otherwise, Legacy agrees to promptly remove its equipment, furniture and fixtures, to the extent applicable, and remove its operations from the Clinic Areas, leaving the Clinic Areas in as good a conditions as it was at the Effective Date of this Agreement, except for reasonable wear and tear arising from the use of the Clinic Area pursuant to the terms and conditions of this Agreement.
3. Galena Park ISD agrees to provide to Legacy:
- a) Galena Park ISD will provide Legacy, with facility space sufficient to host the healthcare staff as described above (the "Clinic Areas") and provide the Services described herein. Notwithstanding anything herein to the contrary, Legacy

acknowledges that it will use the Clinic Areas on an “AS IS”, “WHERE IS” and “WITH ALL FAULTS” basis and hereby expressly waives all warranties, express or implied, including without limitation, warranties of commercial habitability and fitness for a particular purpose; provided however that Galena Park ISD shall be responsible for the maintenance of the foundation, roof, exterior walls, main piping, building equipment and central heating and air conditioning for the Clinic Areas. It is further understood and agreed that the Clinic Areas provided are, after an opportunity to review, deemed suitable by Legacy for the uses contemplated to be made of the Clinic Areas.

- b) Galena Park ISD will provide to Legacy with access to wireless connectivity from the Clinic Areas and access to at least one phone line.
- c) Except to the extent otherwise stated herein, Galena Park ISD shall repair and maintain the Clinic Areas at all times during the term hereof in good condition and repair, including interior, exterior, structure, and roof.
- d) Access to no-charge parking convenient to the space Clinic Areas provided to Legacy, for Legacy personnel on terms no less favorable than that those provided to Galena Park ISD 's staff.
- e) Galena Park ISD will cover the expenses associated with the Clinic Areas, including utilities, maintenance, and other expense related to the use of the space. Clinic Areas to be provided to Legacy includes the following:
 - (i) Adequate amount of space for the Services provided and disabilities treated, including reception area, staff space, examining room, treatment areas, and storage on each School. Areas such as reception, staff space, and storage may be shared spaces. Legacy may provide locked cabinets at its own expense to store documents and materials
 - (ii) The space shall have adequate and comfortable lighting levels in all areas; limitation of sounds at comfort levels; a comfortable room temperature; and adequate ventilation through windows, mechanical means, or a combination of both
 - (iii) Toilet rooms, toilet stalls, and lavatories shall be conveniently accessible

III. Service Opportunity

1. For the duration of this Agreement, Galena Park ISD grants to Legacy a license to occupy and use the Clinic Areas and the right to use any equipment and fixtures, including communications and information systems equipment, cabling and appurtenant items located therein, subject to the terms and conditions hereinafter expressed, for the purposes of providing the Services, including services to students, employees and their respective family

members, both during and after school hours. Notwithstanding the foregoing, Legacy shall only be permitted to utilize the Clinic Areas outside of school hours so long as Legacy arranges for the areas of the School, other than the Clinic Areas, to be reasonably secured from access by Legacy's patients and invitees.

2. In connection with its use of the Clinic Areas, Legacy shall also have the non-exclusive right to use in common with Galena Park ISD any reasonably necessary common areas, parking areas, stairways, elevators, restrooms, hallways, kitchens, break rooms, conference rooms and similar areas, to the extent the regular business of Galena Park ISD is not unreasonably disturbed.

3. Providing that Legacy is in compliance with the terms of this Agreement, and is not causing any unreasonable disruption to Galena Park ISD, Legacy shall and may peaceably and quietly have, hold and enjoy the use of the Clinic Areas, without disturbance, hindrance, ejection or molestation by or from Galena Park ISD or any one claiming by, through or under Galena Park ISD. The Parties acknowledge that as and when matters arise with respect to the use of the Clinic Areas that the Parties shall act reasonably and in good faith endeavor to adjust and resolve such matters.

IV. Patient Consent / Improvement Process

1. The Parties hereto agree that working in collaboration with one another will help bring more individuals into care. For Patients who are referred to Legacy for Services, other than emergency care, it is agreed that the Patients' parents or caregivers must first execute a voluntary Pediatric Consent and Acknowledgement of Services Form (Consent) as contained in Exhibit B prior to the initiation of Services. Galena Park ISD shall provide a copy of the Consent in its Student Handbook beginning at the next reprinting of such handbook. This Consent, once executed by the applicable parties, enables Legacy to initiate Services and provide appropriate follow-up for each Patient as may be necessary. Further, to the extent consistent with applicable law (including, without limitation, 34 C.F.R §99.31, and Federal or State privacy laws,), the consent attached hereto as Exhibit D authorizes Legacy to share patient/student data with Galena Park ISD personnel. Galena Park ISD and its staff shall not have access to confidential health information, except (i) where access shall have been granted by a patient/student or a patient's/student's personal representative (e.g., parent or guardian), or (ii) where Galena Park ISD shall be entitled to receive such confidential health information pursuant to Federal, or State laws, rules and/or regulations such as, but not limited to, 45 C.F.R. § 164.502(g). The Parties agree to comply with all applicable Federal, and State and local laws, rules and regulations in performance of their obligations under this Agreement including such laws respecting the confidentiality of patient/student information (e.g., HIPAA and FERPA). Any data shared pursuant to such consent shall be maintained by the other party on a confidential basis and shall not be provided to any third party, unless required by applicable law. All medical records shall remain the property of Legacy.

2. Each party will communicate openly to review strategies for improving delivery of Services, promote the objectives of this Agreement are fully met, and will meet to discuss this collaboration no less than twice per year.

3. In the provision of the Services the Parties hereto shall give equal opportunity to all persons entitled to receive Services and shall not discriminate for any reason based on race, creed, color, sex, sexual orientation, age, national origin, ethnicity, disability, marital status, religion, or political beliefs or affiliations.

V. Term

1. The term of this Agreement shall commence on the Effective Date, and continue until August 1 2021 ___ (the " Term"), subject to earlier termination of this Agreement, pursuant to the terms hereof. The Term shall be extended for terms of an additional one (1) school year (each, a "Renewal Term") unless either party provides written notice to the other party at least ninety (90) days prior to the expiration of the initial term or the Renewal Term, as applicable, of its intent not to renew the Agreement. In addition, this Agreement may be terminated by either Party at any time by providing thirty (30) days' advance written notice to the other party hereto.

2. Notwithstanding the foregoing, Legacy shall have the right to reevaluate the need for Services at a School at the end of each fall and shall have the right to cease providing onsite Services at the end of any school year to any School that averages fewer than six (6) Patient encounters per day so long as: (1) written notice is provided to Galena Park ISD by January 31 of the year in which Legacy intends to close the clinic; (2) and Galena Park ISD is given a 45 day opportunity to improve. If such improvement is not met and Legacy intends to close the clinic at the end of the school year, Legacy will give GALENA PARK ISD a second written notice no later than March 31 of that year. Of these students, it is estimated that 80% of them qualify for the Free and Reduced Lunch program—an indicator of economic need.

VI. Independent Contractor Status

1. Legacy and Galena Park ISD enter into this Agreement as independent contractors. Legacy and Galena Park ISD are to direct and be responsible for the performance and compensation including payroll taxes, of their respective employees and agents. Legacy or its agents shall not be considered the agent, servant, or employee of Galena Park ISD for any purposes whatsoever. Galena Park ISD or its agents shall not be considered the agent, servant, or employee of Legacy for any purposes whatsoever.

VII. Indemnification

1. To the extent permitted by law, each Party to this Agreement agrees to hold harmless and to indemnify the other Party, its individual employees, agents, trustees, officers, directors, and board members for any and all liability resulting from complaints, grievances, claims,

actions, or suits which arise from performance under this Agreement by each indemnifying organization and its employees, agents, trustees, officers, directors, and board members. Both parties, to the extent permitted by law, shall at all times defend, indemnify, and hold harmless the other party, its trustees, officers, employees, and agents from and against any and all claims for damages for injuries and other losses, including costs and attorney's fees, resulting directly or indirectly from any omission or act of the indemnifying party's officials, employees, agents, subcontractors, or volunteers arising out of the performance of this Agreement, whether such claims are asserted before or after the termination of this Agreement. However, nothing in this paragraph or this Agreement waives or alters any immunity available to either party, its employees, officers or agents under federal or state law.

2. The Parties to this Agreement will provide and maintain during the term of this Agreement insurance coverage with insurers licensed to do business in the State of Texas. Further, the Parties agree to maintain coverage in the type and with coverage and in the amounts equal or comparable to prudent business practices of institutions serving similar industries. Specific requirements of the parties are listed below. The parties shall each be solely responsible for all acts or omissions of their own employees, representatives, agents, assigns, and volunteers. Neither Party shall be responsible for any acts or omissions of the other party's employees, representatives, agents, assigns, and volunteers. As of the signing of this Agreement, each party warrants that it will, upon request, provide evidence of its insurance limitations and carriers to the other party. Each party agrees to provide the other with original certificates of coverage, which shall provide that either party will receive at least thirty (30) days prior notice before alteration, modification, or cancellation of any policies by the other party.

3. Legacy shall name Galena Park ISD as an additional insured and shall maintain and provide evidence to Galena Park ISD, at a minimum, the following coverage:
- a) General Liability: \$1,000,000 per occurrence for bodily injury, personal injury, Sexual Abuse & Molestation, Medical Malpractice, and property damage.
 - b) Workers' Compensation: As required by the State of Texas Employers' Liability: o \$1,000,000 each accident to \$1,000,000 policy limit bodily injury by disease of \$1,000,000 each employee bodily injury by disease.
 - c) Errors & Omissions Liability: \$1,000,000 per occurrence.

VIII. Criminal History Background Check

1. Legacy, hereby certifies that all employees, subcontractors and volunteers of Legacy who work on any Galena Park ISD School where students are present have been fingerprinted in accordance with state requirements for the purposes of working for or with a Texas school district (pursuant to Texas Administrative Code Section 19, §153.1101, Section 19. §153.1117, and Texas Education Code Section §22.0834, 22.0835, and 22.085, passed an

applicable criminal history background check within the last calendar year, and comply with Galena Park ISD's current policy pertaining to criminal histories. All new hires, terminations and volunteers employed by Legacy of employees providing services hereunder must similarly comply with the Galena Park ISD Inc. Board Policy on Criminal Background Checks and Hiring as it exists or may hereafter be amended.

IX. Reporting and Retention of Records

1. Each Party to this Agreement shall be responsible for maintaining any necessary statistics, outcome measures and financial documentation.

2. GALENA PARK ISD and Legacy shall furnish operating reports to designated representatives on a schedule to be mutually agreed upon. Such reports may include, but not be limited to eligibility documents; customer satisfaction surveys by students, parents, school staff and other persons; monthly reports of number of students and families served and types of services provided; and pre, and post-test outcomes collected; GALENA PARK ISD will collect the number and types of absences of referred students and post-referral. Any reports or evaluations incidental to this Agreement, other than those for Legacy's internal management and funding purposes, shall be performed only with the prior approval of GALENA PARK ISD. No reports or evaluations shall be released to third parties without the prior approval of GALENA PARK ISD, except that aggregate statistics may be released to Legacy's funding sources.

3. To the extent that Legacy may come into possession of student records and information, and to the extent that Legacy may be involved in the survey, analysis or evaluation of students, incidental to this Agreement, Legacy agrees to comply with all requirements of FERPA and HIPAA, and agrees to execute and comply with the terms of the attached FERPA Confidentiality Agreement, attached as Exhibit C. GALENA PARK ISD shall use best efforts to timely notify Legacy if GALENA PARK ISD is required to furnish information or records pursuant to the Texas Public Information Act, court order, or other law. If documents requested are maintained by Legacy, the Parties agree to collaborate regarding the privacy and confidentiality provisions of the Texas Public Information Act, state law, and federal law in protecting such documents. GALENA PARK ISD shall have the right to release such information and records as allowed by law and shall, to the extent requested by Legacy, assist Legacy in preserving the privacy of any health treatment records and objecting to disclosure of records under the Texas Public Information Act, where records which are not required to be released under the Texas Public Information Act.

X. Non-Solicitation

1. During the entire Term and for a period of one (1) year thereafter, neither Party shall solicit the services of any employee, consultant, or provider of the other Party hereto for such Party's use or benefit or for any other person's or company's use or benefit, or induce or help to induce any such employee, consultant or provider to leave for other employment, without the engaging or employing Party's prior written consent.

XI. Terms of the Agreement

1. This Agreement shall be governed by the laws of the State of Texas, laws of the United States of America, any applicable executive orders, OMB circulars and their implementation regulations. This Agreement may be terminated for cause effective upon written notice. This Agreement may be amended with the written agreement executed by both Parties.

2. Health Care Fraud and Abuse Compliance

- a) The Parties agree that (1) GALENA PARK ISD may be considered a current or potential source of Patient referrals to Legacy; (2) the charges hereunder, if any, are consistent with fair market value; and (3) reflect fair market value and do not take into account the volume or value of referrals or business that may otherwise be generated between the Parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. The Parties hereby acknowledge and agree that it is not a purpose of this Agreement or any of the transactions contemplated herein to exert influence in any manner over the reason or judgment of any Party with respect to the referral of Patients or business of any nature whatsoever.
- b) To the Parties' knowledge the charges hereunder are: (1) set in advance, (2) do not take into account nor include any additional charges attributable to the proximity or convenience of GALENA PARK ISD as a potential referral source; and (3) would be commercially reasonable even if no referrals were made between GALENA PARK ISD and Legacy.

3. Force Majeure. No Party shall be held liable or responsible to the other Party nor be deemed to be in default under, or in breach of any provision of, this Agreement for failure or delay in fulfilling or performing any obligation of this Agreement when such failure or delay is due to force majeure, and without the fault or negligence of the Party so failing or delaying. For purposes of this Agreement, force majeure is defined as causes beyond the control of the Party, including acts of God; acts, regulations, or laws of any government; war; civil commotion; destruction of production facilities or materials by fire, flood, earthquake, explosion or storm; labor disturbances; epidemic; and failure of public utilities or common carriers. In such event, the affected party shall immediately notify the other Party, with written notice to follow, of such inability and of the period for which such inability is expected to continue. The Party giving such notice shall thereupon be excused from such of its obligations under this Agreement as it is thereby disabled from performing for so long as it is so disabled and for thirty (30) days thereafter. To the extent possible, each Party shall use reasonable commercial efforts to minimize the duration of any force majeure.

4. Venue. Mandatory and exclusive venue for this Agreement shall be a court of competent jurisdiction in Harris County, Texas.

5. Default. The occurrence of any of the following shall constitute a material default under this Agreement:

- i. The failure to make a required payment when due.
- ii. The failure to timely perform any non-payment obligation hereunder.

- iii. The insolvency or bankruptcy of either Party.
- iv. The subjection of any of either Party's property to any levy, seizure, general assignment for the benefit of creditors, application or sale for or by any creditor or government agency.
- v. The failure to make available or deliver the services in the time and manner provided for in this Agreement.
- vi. Any other breach of any other provision of this Agreement.

6. Remedies. In addition to any and all other rights a Party may have available according to law, if a Party defaults by failing to substantially perform any provision, term or condition of this Agreement (including without limitation the failure to make a monetary payment when due), the other Party may terminate the Agreement by providing written notice to the defaulting Party. This notice shall describe with sufficient detail the nature of the default. The Party receiving such notice shall have thirty (30) days from the effective date of such notice to cure the default(s). Unless waived by a Party providing notice, the failure to cure the default(s) within such time period shall result in the automatic termination of this Agreement.

7. Severability. If any provision of this Agreement shall be held invalid, illegal, or unenforceable for any reason or in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision hereof, and the remainder of this Agreement shall nevertheless remain in full force and effect. If any provision of this Agreement shall be held invalid or unenforceable under any particular circumstances, it shall nevertheless remain in full force and effect in all other circumstances.

8. Assignment. Legacy may not assign its rights and duties under this Agreement without GALENA PARK ISD's prior consent, which shall not be unreasonably withheld. GALENA PARK ISD may not assign its rights or duties herein without the prior written consent of Legacy. Any such assignment by either Party without the prior written consent of the other Party shall be null and void. This Agreement may otherwise be assigned upon the written agreement of both parties.

9. Entire Agreement. This Agreement contains the entire agreement of the Parties, and there are no other promises or conditions in any other agreement whether oral or written concerning the subject matter of this Agreement. This Agreement supersedes any prior written or oral agreements between the parties.

10. Amendment. This Agreement may be modified or amended in writing, if the writing is signed by the party obligated under the amendment.

11. Governing Law. This Agreement shall be construed in accordance with the laws of the State of Texas.

12. Notice. All notices required or permitted to be given under the terms of this Agreement shall be in writing, and shall be effective upon delivery if delivered to the addressee in person, effective three (3) business days after mailing if mailed by certified mail, postage prepared, return receipt requested, or effective the next business day if delivered by overnight courier with charges prepaid, as follows:

If to Legacy: Legacy Community Health Services, Inc.
c/o Katy Caldwell, CEO
P.O. Box 66308
Houston, TX 77266

If to Galena Park ISD: Galena Park I.S.D.
c/o Dr. Mechelle Epps
14705 Woodforest Blvd.
Houston, TX 77015

13. Waiver of Contractual Right. The failure of either Party to enforce any provision of this Agreement shall not be considered as a waiver or limitation of that Party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.

14. Expenses. Each Party to this Agreement shall pay its own costs and expenses in connection with the transaction contemplated hereby, except to the extent otherwise set forth herein.

15. Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

16. Binding Effect. This Agreement shall not become effective or legally binding upon either party until signed by both GALENA PARK ISD and Legacy.

1.7 Immunity. Nothing in this Agreement waives or alters any immunities provided Galena Park ISD, its officers, employees, or agents under Texas or federal law.

Executed this 16th day of June 2020,
LEGACY COMMUNITY HEALTH SERVICES, INC.

DocuSigned by:
Katy Caldwell 6/16/2020
918E3E651BB2461...
Katy Caldwell, CEO

GALENA PARK ISD

DocuSigned by:
Sonya George 6/15/2020
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Sonya George, Deputy Superintendent/CFO

EXHIBIT A: LIST OF SCHOOLS

As of August 1, 2020, Legacy shall provide services under this Agreement to the following GALENA PARK ISD schools:

North Shore Senior High School

Green Valley Elementary School

EXHIBIT B: PEDIATRIC CONSENT AND ACKNOWLEDGEMENT OF SERVICES FORM (English and Spanish)



EXHIBIT B Date: _____ Chart # _____
School Based Health Care
 (281) 628 2050

School Name: _____ Grade: _____ Current student: Sibling of current student:
 Staff child:

STUDENT INFORMATION	Student Name : <i>First: _____ Last: _____</i>		Date of Birth:			
	Street:		Apt number:			
	City:		Zip code:			
	Gender: Male: <input type="checkbox"/> Female: <input type="checkbox"/>		Is the student homeless? Yes: <input type="checkbox"/> No: <input type="checkbox"/>			
	Race: White: <input type="checkbox"/> Black/African American: <input type="checkbox"/> American Indian/Alaskan Native: <input type="checkbox"/> Asian: <input type="checkbox"/> Pacific Islander: <input type="checkbox"/> Other: <input type="checkbox"/> I do not wish to report: <input type="checkbox"/>					
	Ethnicity: Hispanic: <input type="checkbox"/> Non-Hispanic : <input type="checkbox"/>					
	Is the student currently a patient of Legacy Community Health (Legacy)? Yes: <input type="checkbox"/> No: <input type="checkbox"/>					
PARENT INFORMATION	1. Parent/Guardian Name:		Date of Birth:	Phone:	Phone – Alternate:	Relationship to student:
	2. Parent/Guardian Name:		Date of Birth:	Phone:	Phone – Alternate:	Relationship to student:
	Emergency Contact Name:			Phone:	Phone- Alternate:	Relationship to Student:
	Parent/ Guardian email:					
INSURANCE	Does the student have insurance? Yes: <input type="checkbox"/> No: <input type="checkbox"/>			Type of insurance: Medicaid: <input type="checkbox"/> CHIP: <input type="checkbox"/> Private: <input type="checkbox"/>		
	If student is uninsured, you may contact Legacy staff to connect you with Legacy’s eligibility department to receive assistance for insurance enrollment and/or determining if you qualify for sliding scale fees.			Name of insurance plan:		
				Insurance ID #:		PO Box Address:

Greater Houston Health Connect (a Health Information Exchange (“HIE”)): I understand that Legacy, along with other participating providers, participates in this HIE, which permits Legacy to access available electronic health information related to me. By my signature, I agree to opt-in so that my health information may be shared with HIE participating providers. This authorization remains in effect unless and until I revoke it and my revocation will be effective within three (3) days. If I do not wish to have my information shared by the HIE, by indicating here _____, I indicate that I am opting out of participating. Additional information about the HIE is available on its website at: www.ghhconnect.org.

EXHIBIT B

Student name: _____ Date of Birth: _____ School: _____

CONSENT FOR MEDICAL SERVICES

-I am the custodial parent or legal guardian of the minor child named above. I understand that I am not required to attend my child's **medical** appointment, but I may, if I choose to do so. I authorize Legacy's nurse practitioner and/or physician to treat my child in my absence and if necessary, an authorized adult may accompany my child to receive medical services. The authorized adult may be a medical assistant, a school nurse, the school principal, a school administrative employee, or an adult named by one of them.

-I understand that I must be present for the initial **therapy** appointment and for each **Psychiatry** appointment.

-I authorize and consent to my child receiving services from Legacy and its affiliated providers. Services may include, but are not limited to:

- Any mandated school health services requested from Legacy.
- Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new school admissions.
- Medically prescribed laboratory tests.
- Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
- Behavioral health services including counseling, therapy, evaluation, diagnosis, treatment and referrals.
- Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on pregnancy prevention, sexually transmitted infections, and HIV, as age appropriate.
- A child in Texas (defined in the Texas Family Code as less than 18 years of age) can consent for the treatment of a reportable infectious, contagious, or communicable disease (for example only and not limited to: HIV/AIDS, other sexually transmitted diseases, tuberculosis and hepatitis); for treatment related to a pregnancy (other than abortion) and, if the child is a self-pay or Medicaid patient, for prescription contraception/birth control.
- I understand that Legacy is required by state law to report information to the City of Houston Department of Health & Human Services when persons test positive for certain diseases (known as "reportable diseases") including, but not limited to, tuberculosis, HIV/AIDS, and syphilis.



Parent/Guardian Signature: _____ Date: _____

DISCLOSURES, RELEASES & AUTHORIZATIONS

- A clinical summary is provided to me following most visits. This summary may be in the form of a letter placed in my child's backpack or delivered through the mail, and/or through a phone call. I understand that some limited information, such as immunization history, may be provided by Legacy to the school and/or local or state health department(s).

-I authorize and direct Legacy to bill on my or my child's behalf and collect payment from any insurance or third party payer that covers the services provided to my child. I understand I may receive a bill for any applicable co-payment or co-insurance amounts. If additional treatment is advised by Legacy providers, a referral will be provided to me at the address and/or phone number of record on this application form.

-Prescriptions, E-Rx or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Legacy participates in E-prescribing because we care about your health and well-being and E-prescribing has multiple benefits. By consenting, Legacy can also access a history of my current and past prescriptions.

-I agree to the terms and information above. I am giving this consent of my own free will. -I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

-I acknowledge receiving information regarding Legacy's notice of privacy practices and understand it is available online at www.legacycommunityhealth.org.



Parent/Guardian Signature: _____ Date: _____

EXHIBIT B

Fecha:

Cuadro #



Cuidado de la salud en la escuela

(281) 628 2050

Nombre de la escuela: _____

Grado: _____

Alumno actual: Hermano de alumno actual: Hijo/a de miembro del personal:

INFORMACIÓN DEL ESTUDIANTE	Nombre del alumno: <i>Nombre:</i> _____ <i>Apellido:</i> _____		Fecha de nacimiento:			
	Calle:		Número:			
	Ciudad:		Código postal:			
	Género: Masculino: <input type="checkbox"/> Femenino: <input type="checkbox"/>		¿El alumno carece de vivienda? Sí: <input type="checkbox"/> No: <input type="checkbox"/>			
	Raza: Blanco: <input type="checkbox"/> Negro/afroamericano: <input type="checkbox"/> Indio americano/nativo de Alaska: <input type="checkbox"/> Asiático: <input type="checkbox"/> Isleño del Pacífico: <input type="checkbox"/> Otra: <input type="checkbox"/> No deseo responder: <input type="checkbox"/>					
	Origen étnico: Hispano: <input type="checkbox"/> No hispano: <input type="checkbox"/>					
	¿Actualmente el alumno es paciente de Legacy Community Health (Legacy)? Sí: <input type="checkbox"/> No: <input type="checkbox"/>					
INFORMACIÓN DE LOS PADRES	1. Nombre del padre/tutor:		Fecha de nacimiento:	Teléfono:	Teléfono alternativo:	Relación con el alumno:
	2. Nombre del padre/tutor:		Fecha de nacimiento:	Teléfono:	Teléfono alternativo:	Relación con el alumno:
	Nombre del contacto para casos de emergencia:			Teléfono:	Teléfono alternativo:	Relación con el alumno:
	Correo electrónico del padre/tutor:					
SEGURO	¿El alumno tiene seguro? Sí: <input type="checkbox"/> No: <input type="checkbox"/>			Tipo de seguro: Medicaid: <input type="checkbox"/> CHIP: <input type="checkbox"/> Privado: <input type="checkbox"/>		
	Si el estudiante no está asegurado, puede comunicarse con el personal de Legacy para contactar al Departamento de elegibilidad de Legacy para recibir asistencia para inscribirse al seguro y/o determinar si califica para el programa de tarifas escalonadas.			Nombre del plan de seguro:		
				Número de identificación del seguro:		Dirección del apartado postal:

Greater Houston Health Connect (un intercambio de información de salud ("HIE", por sus siglas en inglés)): Entiendo que Legacy, junto con otros proveedores participantes, participa en este HIE, que permite que Legacy acceda a la información médica electrónica disponible relacionada con mi persona. Con mi firma, acepto optar por que mi información de salud pueda ser compartida con los proveedores participantes de HIE. Esta autorización permanecerá vigente a menos que y hasta que la revoque, y mi revocación será efectiva dentro de los tres (3) días. Si no deseo que mi información sea compartida por el HIE, lo indico aquí _____, Indico que estoy optando por no participar. Información adicional sobre el HIE está disponible en su sitio web en: www.ghhconnect.org.

EXHIBIT B

Nombre del alumno: _____ Fecha de nacimiento: _____ Colegio: _____

INFORMACIÓN DEL ESTUDIANTE

-Yo soy el padre que tiene la patria potestad sobre o el tutor legal del menor mencionado arriba. Entiendo que no estoy obligado a asistir a la cita médica de mi hijo, pero puedo hacerlo si así lo decido. Yo autorizo a las enfermeras practicantes y/o a los médicos de Legacy para que traten a mi hijo en mi ausencia y de ser necesario, un adulto autorizado puede acompañar a mi hijo para que reciba atención médica. El adulto autorizado puede ser un asistente médico, una enfermera de la escuela, el director de la escuela, un empleado administrativo de la escuela o un adulto nombrado por cualquiera de ellos.

-Entiendo que debo estar presente en la cita inicial del tratamiento y en todas las citas de **psiquiatría**.

-Autorizo y doy mi consentimiento para que mi hijo reciba servicios de Legacy y de sus proveedores afiliados. Los servicios pueden incluir, de manera enunciativa mas no limitativa:

- Cualquier servicio de salud que se solicite a Legacy por mandato de la escuela.
- Examen físico completo (examen médico completo) incluyendo aquellos que sean para la escuela, para deportes, para documentos de trabajo y de nuevo ingreso a la escuela.
- Pruebas de laboratorio prescritas por médicos.
- Atención médica y tratamiento, incluyendo el diagnóstico de enfermedades agudas y crónicas y suministro y prescripción de medicamentos.
- Servicios de salud mental, incluyendo consejería, terapia, evaluación, diagnóstico, tratamiento y derivaciones.
- Educación y asesoría en materia de salud para prevenir comportamientos de riesgo tales como: consumo de drogas, alcohol y tabaco, así como educación sobre prevención de embarazos y de infecciones de transmisión sexual y del VIH, de acuerdo con la edad.
- Un menor en Texas (definido en el Código Familiar de Texas como menor de 18 años de edad) puede dar su consentimiento para el tratamiento de enfermedades infecciosas, contagiosas o transmisibles de declaración obligatoria (por ejemplo solamente y sin estar limitadas a: VIH/SIDA, otras enfermedades de transmisión sexual, tuberculosis y hepatitis); para el tratamiento de un embarazo (excepto aborto) y, si el menor es un paciente que paga por sí mismo o un paciente de Medicaid, para la prescripción de anticonceptivos/medios de control de la natalidad.
- Entiendo que Legacy está obligado por la ley estatal a reportar información al Departamento de Salud y Servicios Humanos de la ciudad de Houston cuando las personas tengan un resultado positivo para determinadas enfermedades (conocidas como "enfermedades de declaración obligatoria") incluyendo, de manera enunciativa mas no limitativa, tuberculosis, VIH/SIDA y sífilis.



Firma del Padre/Tutor: _____ Fecha: _____

DECLARACIONES, COMUNICADOS Y AUTORIZACIONES

-Después de la mayoría de las consultas se me entrega un resumen clínico. Este resumen puede ser una carta colocada en la mochila de mi hijo o puede ser entregado por correo y/o a mediante una llamada telefónica. Entiendo que cierta información limitada, tales como historial de inmunización, puede ser entregada por Legacy a la escuela y/o al (a los) departamento(s) de salud local(es) o estatal(es).

-Autorizo e instruyo a Legacy a facturar en mi nombre o en el de mi hijo y a cobrar el pago de cualquier seguro o de un tercero pagador que cubra los servicios prestados a mi hijo. Entiendo que puedo recibir una factura por montos de coseguro o copago aplicables. Si los proveedores de Legacy aconsejan tratamiento adicional, se me proporcionará la derivación en el domicilio y/o al número telefónico registrado en esta solicitud.

-Las recetas, recetas electrónicas, Rayos X electrónicos, son recetas generadas por computadora creadas por su proveedor y enviadas directamente a su farmacia. Legacy participa en el esquema de receta electrónica porque nos preocupamos por su salud y bienestar y la receta electrónica tiene múltiples beneficios. Al dar su consentimiento, Legacy también puede acceder a un historial de mis recetas actuales y pasadas.

-Estoy de acuerdo con los términos y la información anteriores. Otorgo este consentimiento por mi propia voluntad. He tenido la oportunidad de hacer preguntas y me han sido respondidas en un idioma que entiendo. Además, estoy de acuerdo en acatar los términos de esta autorización. Entiendo que este documento sigue en vigor hasta que revoque mi consentimiento por escrito. También entiendo que puedo revocar mi consentimiento en cualquier momento.

-Reconozco que recibo información sobre el aviso de las prácticas de privacidad de Legacy y entiendo que el mismo está disponible en línea en www.legacycommunityhealth.org.



Firma del Padre/Tutor: _____ Fecha: _____

EXHIBIT C

Agreement for Confidentiality FERPA

The Family Educational Rights and Privacy Act, 20 U.S.C. 1232g, (FERPA) is a federal law that protects the privacy interests of parents and students with regard to education records. It affects every public elementary and secondary school, including GALENA PARK ISD, Inc. ("GALENA PARK ISD").

FERPA defines "education records" broadly to include all records, files, documents, and materials, such as films, tapes, or photographs, containing information directly related to a student that an education agency or institution (such as GALENA PARK ISD) maintains. For example, education records include information that GALENA PARK ISD maintains on students in report cards, surveys and assessments, health unit records, special education records, and correspondence between the school and other entities regarding students.


FERPA restricts the release of education records or information from education records that could identify the student ("personally identifiable information"). Before releasing such records or information to a party outside the school system, the school must obtain consent of the student's parent unless the student is 18 or over, in which case only the student can consent to the release, or unless the release falls under one of the exceptions to the consent requirement.

Statutory exceptions applicable to the prior consent requirement are set forth in detail under Section 99.31 of the FERPA regulations in Part 34 of the Code of Federal Regulations. A common exception is a disclosure made to other school officials who have a legitimate educational interest in the information. A school official includes a person or company with whom the District has contracted to perform a special task. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibilities.

As an independent contractor for GALENA PARK ISD or entity who has contracted with GALENA PARK ISD to perform a special task. If you receive confidential student information or education records about a student as part of fulfillment of your professional responsibilities to GALENA PARK ISD you and/or your company must not disclose the information you receive to anyone who does not have a legitimate educational interest. Furthermore, you are to seek guidance from the person to whom you report to or work with at GALENA PARK ISD before releasing student record information in any part.

My signature below indicates that Legacy Community Health Services, Inc. (Legacy) has read and understood the information and expectations set forth above. Legacy shall comply with FERPA and ensure those who work for it listed below on a project for GALENA PARK ISD are aware of this Agreement and comply with this Agreement.

Authorized signature:

DocuSigned by:

918E3F651BB2461...

(Name)

Legacy Community Health Svcs., Inc.

(Company name)

6/16/2020

Date

Exhibit D

Consent to Disclosure of Health Information



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d) effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|-------------------------------------------------|------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
 _____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ DATE _____
 Signature of individual or individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable): _____
 if representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ DATE _____
 Signature of Minor Individual