Seal a Smile

School Based Oral Health Program

A project of Whitney M. Young Jr. Health Services and the Healthy Capital District Initiative

Dear Parent/Guardian,

The Healthy Capital District Initiative (HCDI) is working with Whitney M. Young Jr. Health Services and your school district, to provide dental care at your child's school.

With permission from their parent/guardian, children in your school will be able to receive a dental screening, cleaning, fluoride treatment and, when appropriate, dental sealants* from a registered dental hygienist.

> ***A dental sealant** is a thin plastic coating that is applied to healthy permanent molars. According to the Center for Disease Control, children with sealants develop 70% fewer new cavities on sealed teeth. Applying sealants to teeth is painless and simple.

- Children insured by Medicaid will be paid in full by Medicaid.
- Children insured by Child Health Plus will be paid in full by CHP**. If they have not had 2 cleanings in the past 12 Months**
- Uninsured families will be encouraged to work with a Facilitated Enroller to apply for Child Health Plus and free or low cost care.
- Children with private insurance may have co-pays. Please check with your insurer before signing up for services.

If your child has a dentist, we recommend that you consult with him/her prior to participating in our program. It is infrequent for children to need their teeth cleaned more than once every six months and insurance often does not cover more than 2 cleanings a year.

If your child does not have a dentist, upon the completion of your child's care, you will receive a parent report on their oral health. Should your child need additional treatment, and does not have a regular dentist we can help you find one.

If you have any questions about the program please contact us, or your school nurse.

Please return the attached forms to school tomorrow.

Seal a Smile Oral Health Program: 315 Sheridan Ave, Albany, NY 12206
Phone: (518) 462-7049, Fax: (518) 462-7021

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Consent Form

Dear Parents/Guardians, to provide services to your child you must complete this consent form.

School: _____ Teacher: _____ Grade: _____

Childs' Name: _____ DOB: _____ Gender M F

Student's Social Security # _____-____- _____ (required)

Parent Name: _____

Home address: _____ City: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Emergency contact person:
Name: _____ Relationship (to child): _____

Phone: (H) _____ (Cell): _____

☐ **No,** I do not want my child to participate in the program at this time.

Signature of Parent or Guardian _____ Date: _____

☐ **Yes,** I want my child to receive dental education, screening and a parent report. I understand that up to date insurance information is required for my child to receive dental cleaning, fluoride treatment, and sealants to fully protect their teeth. Uninsured children can receive full services as well if they call 462-7049 to make arrangements.

Insurance Information

Medicaid, Fidelis, Well Care, CDPHP, GHI

ID/CIN # _____

Group # _____

Private Dental Insurance

Company _____

Enrollee (employee)_____

ID/CIN # _____

Group # _____

We must have the information on the back completed to serve your child.

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Has your child ever had any of the following? **Please check <u>Yes or No</u>.**

	YES	NO		YES	NO
Heart Disease			Asthma		
Heart Murmurs			Tuberculosis		
Rheumatic Fever			Hemophilia/Bleeding disorder		
Kidney Disease			Seizure disorder		
Anemia			Hearing loss		
Diabetes			Vision problems		
Hepatitis/Liver Disease			Serious injuries		
Sickle Cell Trait			Artificial joints		
Operations/Hospitalizations			Other Health Issues:		
Does your child take medications Please list medications: (Attach list if necessary.)			Allergy to Latex? _____ Other Allergies**:(Attach list if necessary)**		

<u>Please circle Yes or No</u>

Does your child drink fluoridated water? **Yes / No**

Does your child receive a daily <u>fluoride</u> supplement / vitamin? **Yes / No**

Does your child have a dentist? **Yes / No**

Dentist Name: _____ Address: _____ Phone: _____

Physician name_____Address: _____ Phone: _____

I give permission for my child to participate in the Seal a Smile School Based Dental Program. I also give permission for Seal a Smile staff to exchange information about my child's oral health, health insurance and parent/guardian contact information with my child's dentist, doctor and school district. If my child has health and/or dental insurance, I have provided the Medicaid or CHP number.

Signature of Parent or Guardian: _____ Date: _____

Print Name of Parent or Guardian: _____ Date: _____

Please send me a survey to provide comments or suggestions to how Seal a Smile School Based Dental Services can best serve your school. **Yes / No**

Please place this form in the envelope provided and return it to school. Thank you

(Office use) Consent and Health Hx: reviewed:

_____RDH, _____Date

Rev. 2.12.07

Dear Parent/Guardian:

We are required under the Health Insurance Portability and Accountability Act ("HIPAA") to provide each parent/guardian with a copy of this information. It is also required that you acknowledge receipt of this information. Please sign below and return this letter along with the consent form to school. **Thank you.**

I acknowledge receipt of information regarding my Protected Health Information.

Signature: _____ Date: _____

Please place this form in the envelope provided and return to school.

Thank you

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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.

We are required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: We may use PHI for the purposes of treatment, payment and health care operations, in most cases without your written permission. Examples of our use of your PHI:
For Treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI telephone or written to the hospital another office.
For Payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.
For Health Care Operations. This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Use and Disclosure of PHI Without Your Authorization. We are permitted to use PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including: For the treatment, payment or health care operations activities of another health care provider who treats you; For health care and legal compliance activities; To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests; To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence); For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process; For law enforcement activities in limited situations, such as when responding to a warrant; For military, national defense and security and other special government functions; To avert a serious threat to the health and safety of a person or the public at large; For workers' compensation purposes, and in compliance with workers' compensation laws; To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation; For research projects, but this will be subject to strict oversight and approvals;Use or disclose health information about you in a way that does not personally identify you or reveal who you are. Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.
Patient Rights: As a patient, you have a number of rights with respect to your PHI, including: The right to access, copy or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee, as state law permits, to provide a copy of any medical information you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have forms available to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect or obtain a copy of your medical information, you should contact our local privacy representative. The Right to Amend Your PHI. You have the right to ask us to amend written medical information we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request an amendment of the medical information we have about you, please contact our local privacy representative to obtain an amendment request form.

The Right to Request an Accounting. You may request an accounting from us of certain disclosures of your medical information we have made in the six years prior to the date of your request. However, your requests for an accounting of disclosures cannot precede the implementation date of HIPAA April 14, 2003. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact our local privacy representative. The Right to Request That We Restrict the Uses and Disclosures of Your PHI. You have the right to request that we restrict how we use and disclose your medical information we have about you. We are not required to agree to any restrictions you request, but any restrictions agreed to by us in writing are binding on us.

Revisions to the Notice: We reserve the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our privacy official.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to our privacy official.