WISCONSIN Seal-A-Smile

Community Health Systems School Based Oral Health Program

Community Health Systems is again offering a preventive dental sealant program. This program is funded by the Wisconsin Seal-A-Smile, a collaborative program of Children's Health Alliance of Wisconsin and the Wisconsin Department of Health Services. A licensed dental provider will come to the school to provide the sealant program at no charge to you. The program includes: assessment to determine if sealants can be done, sealants if appropriate, fluoride treatments, toothbrush, and a follow-up letter will be sent home to describe what was completed and what is recommended for future needs.

Child Last Name: _____ **First Name:** _____ **Date of Birth** ___/___/____ **Male/Female**

Child's Teacher: _____ **Grade:** _____ **School:** _____ **WI Student ID #**_____

Guardian Last Name: _____ **Guardian First Name:** _____ **Guardian Date of Birth** ___/___/____

Guardian Address: _____ **Guardian Phone Number:** _____

Ethnicity (select one): ○ Hispanic ○ Non-Hispanic ○ Unknown

Race (select one): ○ White ○ Black/African American ○ Asian ○ American Indian/Alaska native ○ Unknown/not available ○ Native Hawaiian/Pacific Islander

Does your child:

- use medicine prescribed by a doctor? YES NO **If yes, what kind?** _____
- need or use more medical care than other children the same age? YES NO
- have trouble doing things most children the same age can do? YES NO
- need or get special therapy, such as physical therapy, occupational therapy or speech therapy? YES NO
- need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or activities other children the same age can do? YES NO

If you selected "yes" to any of the questions above: Has this problem lasted or is expected to last at least 12 months? YES NO

Does your child have any allergies? (to medications, food, latex, etc.) YES NO If yes what are they? _____

Has your child ever been seen by a dentist? YES-within one year YES-over one year Never been seen by a Dentist

What type of DENTAL insurance does your child have? **Note: No student will be refused services based on their insurance coverage or lack of**

○ Forward Health/Medicaid/BadgerCare ○ Private Insurance (Delta Dental etc.) ○ No Insurance ○ Other _____

Medicaid #_____

◯ **YES,** I do want my child to participate in a school-based dental prevention program and authorize Forward Health or any other third party insurance company to be billed for billable services. **There are no copays or deductibles charged.** I give the school permission to share my child's WI Student ID number with the school-based program.

- I understand the nature of the treatment provided and authorize Community Health Systems staff to provide oral health treatment
- I acknowledge that I have received the CHS Notice of Privacy Practices that explains how information collected for treatment may be used or disclosed to my insurance company or orther health care providers
- I understand that this permission is effective for a period of 24 months in order to provide follow-up services, including multiple fluoride treatments
- I understand that I may contact Community Health Systems at 608-313-3128 EXT 1031 for questions concerning the Seal-A-Smile Program

_____/_____Date ___/___/____

(Print) parent/guardian (signature) Parent/guardian

◯ **NO,** I don't want my child to participate in the school-based dental prevention program. (Sign and return to your child's school)

_____/_____Date ___/___/____

(Print) parent/guardian (signature) parent/guardian

***The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow up care which may be recommended after your child has completed this school based oral health program. All procedures will follow recommendations from the American Dental Association and Centers for Disease Control and Prevention's recommendations for school-based dental sealant programs.**

For office use only Health History REVIEWED BY: _____ Date:_____

Notice of Privacy Practices

Community Health Systems School Based Oral Health Program

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

The Community Health systems and the School District are required by law to maintain the privacy of the Seal-A-Smile Program participant's health information and to provide you with this Notice of Community Health Systems legal duties and privacy practices with respect to your child's protected health information (PHI). The Community Health systems and the School District are required to abide by the terms of the notice currently in effect.

How We May Use and Disclose your Child's PHI

For Treatment. The Community Health systems (CHS), the School District (SD), (hereafter referred to as CHs, and SD) may use your protected health information (PHI) to coordinate care with other health professionals. CHS may notify school personnel of the need for additional dental care services, or may need to contact your child's physician related to medical issues (e.g., heart murmur or organ transplant) prior to providing dental sealants. The school nurse may be able to refer you to appropriate sources for needed dental care.

For Payment. We may include your child's PHI to collect payment from Medicaid or a Medicaid managed care plan for dental sealant your child receives through the sealant program.

Health Care Operations. We may use or disclose PHI in order to facilitate the general administration of the program. For example, your child's health information may be used to evaluate staff performance or it may be combined with that of others to evaluate how to more effectively serve all the program recipients.

Business Associates. We may share your child's PHI with third –party "business associates" who perform activities for us (e.g., billing). Whenever an arrangement with a business associate involves the use or disclosure of PHI, we will have a written contract that contains terms that will protect the privacy of this PHI.

Other Uses and Disclosures

As Required by Law. CHS and SD will disclose your child's PHI when required to do so by any federal, state or local law.

Public Health and Communicable Disease. We may disclose your child's PHI for public health reasons, activities and purposes in order to prevent or control disease, injury or disability or to report reactions to products regulated by the Food and Drug Administration, or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading disease.

To Report Abuse, Neglect or Domestic Violence. CHS and SD are required by law to notify government authorities if they believe a patient is the victim of abuse, neglect or domestic violence.

Legal Proceeding and Law Enforcement. We may disclose PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. CHS and SD may disclose your child's PHI to law enforcement officials for certain law enforcement purposes such as locating a missing person or under certain limited circumstances, when your child is then victim of and crime.

Research, Health and Safety, and Certain Specialized Government Functions. Although it is highly unlikely your child's PHI will be needed for these purposes, CHS and SD may in certain circumstances share PHI with coroners or funeral directors, for research purposes, or to avert a serious threat to the health and safety of an individual or the public. PHI may be shared for specialized government functions such as disclosures related to military personnel and veterans, national security and intelligence gathering; medical suitability determinations, correctional institutions and other law enforcement custodial situation, government programs providing public benefits, and disclosures related to Worker's Compensation.

Required Uses and Disclosure. Under the law, we must make disclosures to you, with certain exceptions, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

Authorized Uses and Disclosures. Additional uses and disclosure may be made if you have given written authorization, which may be revoked at any time in writing delivered to the site compliance contact, except to the extent the health department acted in reliance on the authorization.

Your Rights

Restrictions. You have the right to request restriction on the use and disclosure of your child's PHI; however, the health department will be bound by the restrictions only if you are notified in writing that the health department has agreed to the requested restriction.

Confidentiality. You have the right to have the health department use only confidential means of communicating with you about child's PHI. This means you may have information mailed to your home instead of sent home with your child.

Access. You have the right to see and receive a copy of the PHI kept about your child by the sealant program under most circumstances.

Amendment. You have the right to have the health department amend its records of PHI about your child. The program may refuse to amend information that is accurate, that was created by someone else or is not disclosable to you.

Accounting. You have the right to see a list of disclosures of PHI about your child, which includes the purposes and recipients of the information

Copy. You have the right to receive a paper copy of this notice.

Privacy Notice. The CHS and SD are required by law to keep the PHI about your child private and to give you this notice. However, CHS and SD reserve the right to amend this notice and make such change applicable to all health information maintained without prior notice.

Complaints. You may complain to CHS if you believe your child's privacy rights have been violated by giving a written complaint to the health department's site compliance contact, Julie M. Roethler, RN, 74 Eclipse Center, Beloit, WI, 53511, 608-299-3317 ext 1032

You may also complain to the Secretary of the Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Surite 240, Chicago, IL 60601; (312) 886-2359; (312) 353-5693 (TDD); (312) 886-1807 FAX. You will not be retaliated against in any way for filing a complaint.

Effective date. This notice is effective from August 24, 2010 until revised by the CHS.

You may be asked to sign an acknowledgement that you received this Notice of Privacy Practices. This notice was published and becomes effective on August 24, 2010.

Reviewed and Revised 07/29/15 CLW

Community Health Systems Seal-A-Smile Program
Private Insurance Information Form

Insurance Company Name: _____

Insurance Company Phone Number: _____

Subscriber (Member) Name: _____

Subscriber (Member) ID# or SSN: _____

Subscriber (Member) Date of Birth: _____

Group Number: _____

If there are any questions regarding any of the information needed, please contact the Dental Clinic at (608) 313-3128 ext. 1076. Thank you.

Community Health System Programa de Seal-A-Smile
Informacion de Aseguranza Privada

Nombre de la Compania de Aseguranza: _____

Numero de telefono de la Compania: _____

Nombre del Suscriptor (Miembro): _____

Numero de ID o Numero de Seguro Social del Suscriptor: _____

Fecha de Nacimiento del Suscriptor (Miembro): _____

Numero de Grupo: _____

Si tiene alguna pregunta aserca de la informacion requerida, por favor llame a la clinica dental al (608) 313-3128 ext. 1076. Gracias

"Quality Care For All"