



Choptank Community Health System
Dorchester County School Based Dental Program
Healthy Children Are Better Learners

Dear Parent/Guardian:

As a student in the Dorchester County Public School system, your child has access to the **School-Based Dental Program**. The program is a partnership between the Dorchester County Public Schools, Dorchester County Health Department and Choptank Community Health System. If you enroll your child in the program, he/she will be seen by a dental hygienist in order to provide care that promotes healthy teeth and gums.

Services: Services may include: a dental screening, cleaning, fluoride treatment, sealants and if needed, referrals for prescriptions and dental emergencies.

The CCHS School-Based dental staff utilizes progressive mobile dental equipment and follows all regulations regarding appropriate sterilization, safety and health procedures. Whenever your child is seen by the school-based dental staff, a note is sent home that details the visit. You will receive information on your child's oral health status as well as a list of the services provided during the visit. Additionally, a report on your child's visit is shared with your child's dentist, if you list one on the enrollment form.

The school based program does not take the place of your regular dentist. A dental hygienist will screen your child to determine which services will be provided or if a referral is necessary. Your child should go to your dental office for a complete exam with x-rays as often as recommended by your dentist.

Cost: Federal and state regulations require all providers, including Choptank Community Health System (CCHS), to bill all patients for School Based Dental program services. The Medicaid Healthy Smiles program covers preventive dental services in the school setting. If your child has dental insurance, we will bill the insurance company for dental services and follow the billing requirements associated with your plan. Depending on your insurance plan, you may receive a bill from CCHS for copays and/or deductibles. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon their income. All patients are eligible to apply for the sliding fee program even if they have insurance.

Enrollment: All Dorchester County Public School students can enroll in the program. Please complete the attached enrollment and consent for release of information form. If you have questions about the program, please contact Choptank Community Health System at (410) 479-4306, ext 5012.

Choptank Community Health System, Inc. Notice of Privacy Practices
Effective April 14, 2003

This Notice of Privacy Practices describes the personal information we collect, how and when we may use or disclose this information. It also describes your rights and our responsibilities related to your protected health information.

How will CCHS use your Protected Health Information?

1. We will use your health information for treatment. Information obtained by the staff will be recorded in your medical record and used to determine the course of treatment that should work best for you.
2. We will use your health information for payment. A bill may be sent to you or your insurance company. The information on or with the bill may include information that identifies you as well as your diagnosis, procedures and supplies used during your visit.
3. We will use your health information for regular health operations. Members of the quality improvement team may use information from your health record to assess the care and outcomes in your case and others like it. This information may then be used as we strive to continually improve the quality and effectiveness of the health care we provide.

Additional ways we may use your health information:

1. There are some services provided in our organization through contracts with business associates. We may disclose your health information to them.
2. Unless you notify us that you object, we may use your name for directory purposes.
3. We may disclose information to notify a family member, a personal representative or another person responsible for your care of your location and general condition.
4. We may disclose your information for research purposes when researchers have established protocols to ensure your privacy.
5. We may disclose information to organ procurement organizations for the purposes of tissue donation or transplant or to funeral homes.
6. We may contact you to provide appointment reminders or information about treatment alternatives for you.
7. We may contact you as part of a fundraising effort.
8. We may use your information to enable product recall, repairs or replacement.
9. We may use your information to comply with laws such as workers compensation or similar programs.
10. We may disclose your information to public health or legal authorities charged with preventing or controlling disease, injury or disabilities.
11. We may disclose your information to correctional institutes of for law enforcement.

Your health information rights:

- Obtain a copy of this notice.
- Inspect and copy your health record.
- Amend your health record.
- Obtain an accounting of the disclosures of your health information.
- Request communications of your health information by alternative means.
- Request a restriction on certain uses and disclosure of the information.
- Revoke your authorization to use or disclose your health information.

CCHS is required to:

- Maintain the privacy of your health information.
- Provide you with this notice describing our legal duties and privacy practices.
- Abide by this agreement.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means.

CCHS reserves the right to change our practices and to make the new provisions effective for all the protected health information we maintain. Should our privacy practices change, we will provide you with a copy of the revised notice. We will not disclose or use your health information without your authorization (except as described in this notice). We will also discontinue to use or disclose your health information after we receive your written request.

For more information or to report a problem, contact the CCHS Chief Operating Officer/Privacy Officer at 410-479-4306. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, NE, Room 509 F, HHH Building, Washington DC, 20201. There will not be retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.

Choptank Community Health System Dorchester County School Based Dental Program Enrollment Form

My child is a student at:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Sandy Hill Judy Center | <input type="checkbox"/> Sandy Hill Elementary | <input type="checkbox"/> Mace's Lane Middle | <input type="checkbox"/> North Dorchester Middle |
| <input type="checkbox"/> Choptank Elementary | <input type="checkbox"/> South Dorchester K-8 | <input type="checkbox"/> Hurlock Elementary | <input type="checkbox"/> Hurlock Head Start |
| <input type="checkbox"/> Vienna Elementary | <input type="checkbox"/> Maple Elementary | <input type="checkbox"/> Warwick Elementary | <input type="checkbox"/> St. Clair Head Start |
| <input type="checkbox"/> Cambridge-South Dorchester High | | <input type="checkbox"/> North Dorchester High | |

Student's name _____		
Last	First	Middle
Home address _____		
Street	City	State/Zip
Phone _____	Social Security# _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth _____	Race _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
Grade _____	Homeroom _____	

Parent/legal guardian name _____		
Relationship to student _____		
Address (if different than student) _____		
Phone: Home _____	Work _____	Cell _____
In case of emergency call		
Name _____	Phone _____	
Name _____	Phone _____	

Does your child have health insurance?	
<input type="checkbox"/> NO, please send a sliding fee program application.	
<input type="checkbox"/> YES, please complete the following:	
Name of insurance company _____	
Policy/Medical Assistance # _____	Group # _____
Insurance billing address _____	
Policy holder name _____	Policy holder DOB _____
Does your child have a Doctor/Primary Healthcare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Doctor/Primary Healthcare provider _____	
Address _____	Phone # _____
Name of Dentist _____	Phone # _____
Pharmacy _____	

I understand that my signature gives consent for the CCHS School Based Dental Providers to provide dental services for my child and to communicate with my child's primary dental care provider. I understand that my signature indicates that I have received a copy of the Notice of Privacy Practices. I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. CCHS may also mail dental care information to my home. I understand that my child's dental information will be used for treatment, payment and health care operations. I recognize that school records may be used to obtain information left blank on the enrollment form. I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles. If I do not have insurance, I will be billed based upon your income.

Parent/Guardian Signature _____ **Date** _____

**Choptank Community Health System
Dorchester County School Based Dental Program Enrollment Form**

List all medications your child takes daily or, on a regular basis:

Medication _____ mg _____ Directions _____
 Medication _____ mg _____ Directions _____
 Medication _____ mg _____ Directions _____

Allergies:

Medication No Yes Name of medication(s) _____

Reaction to medication(s) _____

Food No Yes Source of Allergy _____

Environmental: No Yes Source of Allergy _____

Does your child have a doctor's order for an Epipen? No Yes

Does anyone in your home smoke? No Yes

DOES YOUR STUDENT HAVE/HAD ANY OF THE FOLLOWING? CONDITIONS	CHECK ALL THAT APPLY STUDENT	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S DENTAL NEEDS
ADD/ADHD		
ASTHMA ♦ WHEEZING ♦ BREATHING		
BLEEDING DISORDER		
CANCER		
DEPRESSION ♦ MENTAL ILLNESS		
DIABETES		
DRUG ♦ ALCOHOL ♦ TOBACCO USE BY STUDENT / HOUSEHOLD		
HEARING ♦ VISION PROB. ♦ LOSS		
HEART PROBLEMS <input type="checkbox"/> Congenital <input type="checkbox"/> Requires Antibiotics		
HIGH BLOOD PRESSURE		
HIV/AIDS		
JOINT REPLACEMENT		
LEAD POISONING		
LIVER PROBLEMS (HEPATITIS)		
MENTAL RETARDATION		
MIGRAINES		
SEIZURE DISORDER (EPILEPSY)		
STOMACH PROBLEMS		
TOOTH DECAY		
TUBERCULOSIS		
ANY OTHER HEALTH ISSUES:		
	<i>Reviewed By</i>	<i>SB Dental Hygienist</i> _____

**Choptank Community Health System
Dorchester County School Based Dental Program Enrollment Form**

Student's Name _____ Date of Birth _____

DENTAL HISTORY: Please circle Yes or No.

- YES NO** Has your child complained of mouth pain within the last six months?
YES NO Does your child routinely visit a dentist for six month check ups?
YES NO Do you need help in finding a dentist?

Child's dentist and/or office name _____

Dental Office phone number _____

Date of last dental cleaning _____

Date of next cleaning _____

Name of Doctor/Primary Health Care Provider _____

Please return this form to the School Nurse or the Wellness Center.

For completion by School-Based Dental Staff:

When obtaining information by phone regarding past and/or pending appointments for this student; please note name of primary dental office staff with whom you spoke:

Name _____
Primary Dental Staff

Date _____

Reviewed By _____
SB Dental Hygienist