NOTICE: Bement School Dental Clinic October 22nd and 24th

Dear Parent or Guardian:

The DeWitt Piatt Bi-County Health Department will be coming to your child’s school to provide important oral health services to the students. The Dental Sealant Program is an Illinois Department of Public Health (IDPH) grant funded program.

Participation in the Dental Sealant Program:

- The attached consent form is to be completed and signed by the parent or guardian. The Dental staff will see all students with completed-signed forms.

  All students regardless of income level are eligible to receive a screening.

- If the child falls within certain income guidelines mandated by the IDPH grant, the child will be eligible to receive cleanings, fluoride treatment, and dental sealants.

- For Kindergarten, 2nd and 6th grades, School Dental Exam forms will be signed and given to the School Nurse.

It is our hope that all students will take advantage of this beneficial program. All students seen by the dental staff will receive a letter to their parents or guardian indicating what was done and if any oral health problems were found during the dental screening.

Please review and keep the Notice of Privacy Practices.

Please fill out the attached consent form and return it to your child’s teacher.

THIS EXAMINATION FULFILLS THE IL STATE LAW REQUIRING THAT ALL K, 2nd, and 6th GRADERS HAVE A MANDATORY DENTAL EXAM. YOUR CHILD’S DENTAL EXAM FORM HAS BEEN TURNED IN TO THE SCHOOL’S OFFICE AND WILL BE PLACED IN HIS/HER PERSONAL FILE.

Thank You!!

The Dental Staff
NOTICE OF PRIVACY PRACTICES

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.

DeWitt-Piatt Bi-County Health Department (DPBHD) creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. The uses and disclosures described in this Notice are applicable to the health department.

DPBHD is required by federal and state law to maintain the privacy of your protected health information (PHI). DPBHD is also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: DPBHD obtains medical information about you in treating you. This medical information is called "protected health information" or "PHI." Your PHI is used to treat you. DPBHD may send your PHI to a physician or counselor to whom you are referred for treatment. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits or services that are offered. If you have a friend or family member involved in your care, DPBHD may give them PHI about you.

Payment: DPBHD uses your PHI to obtain payment for the services that are rendered. For example, PHI is sent to Medicaid, Dentcaquest, Medicare and or private insurance companies to obtain payment for our services.

Health Care Operations: DPBHD uses your PHI for our operations. For example, DPBHD may use your PHI in determining whether we are giving adequate treatment to our clients such as quality control reviews of the file. From time to time, DPBHD may use your PHI to contact you to remind you of an appointment either by phone or mail.

Legal Requirements: DPBHD may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

- Public Health: DPBHD may use and disclose your health care information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

- Health Oversight Activities: DPBHD may use and disclose your PHI to state agencies and federal government authorities when required to do so. DPBHD may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, DPBHD must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule, the Illinois Department of Human Services or Illinois Department of Public Health in annual review of the grant funded programs (WIC, FCM, APORS, Dental Sealant Program), to the Illinois Department of Professional Regulation in an investigation of professional neglect complaints.

- Judicial and Administrative proceedings: DPBHD may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI by the party seeking the information.

- Law Enforcement: DPBHD may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. DPBHD may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

- Avert a Serious Threat to Health or Safety: DPBHD may use or disclose your PHI to stop you or someone else from getting hurt.

- Work-Related Injuries: DPBHD may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

- Coroners, Medical Examiners, and Funeral Directors: DPBHD may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

- Armed Forces: DPBHD may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. DPBHD may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.
National Security and Intelligence: DPBHHD may use or disclose PHI to maintain the safety of the President or other protected officials. DPBHHD may use or disclose PHI for the conduct of national intelligence activities.

Correctional institutions and custodial situations: DPBHHD may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclose PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: Should DPBHHD undertake any fundraising activities, we may contact you about the fundraising activity. DPBHHD does not engage in marketing activities, and would need your authorization to do so.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, dental records and alcohol or drug abuse treatment, you will be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal privacy laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. DPBHHD is not required to agree to your request.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that DPBHHD only call you at home. If your request is reasonable, we will accommodate it.

Inspect and Access: You have a right to inspect information used to make decisions about your care. This information includes billing and medical record information. You may not inspect your record in some cases. If you request to inspect your record is denied, DPBHHD will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, DPBHHD may charge you a fee for making the copies by paper or electronically and mailing them to you, if you ask us to mail them to you.

Amendments of your Records: If you believe there is an error in your PHI, you have a right to request that DPBHHD amend your PHI. DPBHHD is not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that DPBHHD has made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. DPBHHD has also posted this Notice at the office in each county.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with the health department by calling our Privacy Officer at (217)935-3427. DPBHHD will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services, Washington D.C. if you feel your privacy rights have been violated.

DPBHHD does not maintain a facility directory so that if family or friends ask us about your condition, we cannot tell them general information nor the fact that you are here. If family or friends say that it is an emergency for them to reach you, we will page you. If you want us to tell someone you are here, please tell us k now.

DPBHHD is required to abide with terms of the Notice currently in effect, however, DPBHHD may change this Notice. If DPBHHD materially change this Notice, you can get a revised Notice on our website at www.dewittiathealth.com, or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

Should DPBHHD seek help from individuals or entities who are not part of this Notice in our treatment, payment, or health care operations activities, DPBHHD will require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule.

EFFECTIVE DATE: April 14, 2003
REVISED DATE: May 8, 2014
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DENTAL EXAM & TREATMENT PERMISSION FORM

COUNTY: _______________________________ TEACHER: _______________________________ GRADE: _______________________________

SCHOOL: _______________________________ AGE: _______________________________

Dear Parent or Guardian: The DeWitt Piatt Bi-County Health Department has arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, registered dental hygienists and agency staff will come to your child’s school with portable equipment to provide these services. In some situations the dentist will examine your child’s teeth one day and the hygienist will clean, apply fluoride and seal the teeth on a different day. In order for your child to receive these services you must provide all the information requested and sign and initial in the areas indicated.

Child’s Name: _______________________________ Birthdate: _______________________________

Address: _______________________________

City: _______________________________ State: IL Zip: _______________________________

Phone: _______________________________ Gender: M or F Race: _______________________________

Does your child qualify for free or reduced meals at school? YES or NO

Please fill in the following questions if you do not know whether you qualify for free or reduced lunches:

1. Number of family members: _______________________________
   2. Income per year: _______________________________

Is your child enrolled in the “All Kids” state insurance program (Medicaid)? YES or NO

If your child is enrolled please post the 9 digit ID number from the back of the medical card: _______________________________

Is your child enrolled in a Managed Care Organization? YES or NO

If your child is enrolled in a MCO, please write the name of the company and the ID number from their card: _______________________________

Examples are: Molina, Meridian or Health Alliance Connect. The company may have been assigned to you by Medicaid.

This number must be filled in to allow us to bill Dentaquest of Illinois for the dental services provided.

***************SEE REVERSE SIDE FOR MEDICAL CONTRAINDICATIONS***************

SIGNATURE: _______________________________ DATE: _______________________________

In signing this form, you give permission to treat your child and also verify that you have read the additional form regarding HIPAA. This will also give permission for Illinois Department of Healthcare and Family Services and the Illinois Department of Public Health to review quality assurance by allowing them and the Health Department to return to the school to re-check your child’s sealants.

***If you do not want to participate in the dental sealant program for your child just mark “NO” at the top of the page.***

***************SEE REVERSE SIDE FOR MEDICAL CONTRAINDICATIONS***************
Does your child have any speech difficulties? YES or NO

Is your child taking any prescription or over the counter medications at this time? YES or NO

IF yes, please list:
1. 
2. 
3. 

Has your child ever suffered from injuries to the mouth, head or teeth? YES or NO

What type of water does your child drink? city well bottled filtered

Does your child have a retainer, braces, or artificial teeth? YES or NO

Has your child ever had a history of or conditions related to any of the following items?

Please place an X by the items related to your child.

Anemia Arthritis Asthma Bladder Bleeding Disorders Bones/Joints Cancer

Cerebral Palsy Chicken Pox Chronic Sinusitis Diabetes Earaches Epilepsy

Fainting Growth problems Hearing Heart Hepatitis HIV/AIDS Immunizations

Kidney Latex allergy Liver Measles Mononucleosis Mumps Pregnancy

Rheumatic Fever Seizures Sickle Cell Thyroid Tobacco/drug use Venereal disease

Other – please list here:

Parents Initials: _______________________

DEWITT PIATT BI-COUNTY HEALTH DEPARTMENT

PO BOX 518, 5924 REVERE ROAD

CLINTON, IL 61727-0518

Dental sealant permission form 2015/cir/8/2014