# OTTAWA COUNTY HEALTH DEPARTMENT FREE DENTAL SERVICES FOR CHILDREN

## WHO

Children 0-18 years old with **Medicaid insurance or uninsured** who:

- Do not have a dentist and
- Have not had a dental checkup in the last 6 months and
- Qualify financially

## WHAT

- Dental checkup
- Teeth cleaning
- Fluoride treatment to prevent cavities
- X-rays
- Sealants
- Dental Health Education
- Fillings and extractions if needed
- Other necessary dental treatment

## WHERE

The “Miles of Smiles” Mobile Dental Unit will come to your child’s school to provide Dental Services.

## HOW

1. Fill out the attached Health History Form ***completely***.
2. Child’s Medicaid Recipient ID # ***must*** be written on attached form (if Medicaid eligible)
3. Return Health History Form to school ***immediately***.
4. Financial information ***must*** be completed on attached form.

*Thank you.*

## DENTAL INSURANCE

Due to state budget cuts, “Miles of Smiles” has limited grant monies to provide fillings for low-income, uninsured children.

**If your child qualifies for Free/Reduced Lunch, they would also qualify for low-cost ($0 - $10 per month) medical and dental insurance for all children in the family.** Please call 1-800-764-4111 ext. 5731 or (616) 393-5731 for assistance in completing the MIChild application. The application may also be completed on-line at www.healthcare4mi.com.

***Apply now to ensure that your child receives the dental care they need on “Miles of Smiles”!***

**Información en español en el otro lado de esta página.**

# "MILES OF SMILES" Dental Mobile Unit
# OTTAWA COUNTY HEALTH DEPARTMENT
# CHILD DENTAL REGISTRATION AND HEALTH HISTORY

Child's Name (First MI Last) Sex Birth date

Parent's Name Telephone

Address City State Zip

**To receive dental services this portion must be completed:** Have you applied for Medicaid coverage for your child in the last 90 days? Yes ☐ No ☐

Child's Medicaid/Recipient ID # ______________ Child's Social Security Number ______________

How many people are in your household?______ What is your **monthly** household income before taxes? $______________

School presently attending: ______________ Grade ________ ☐ AM ☐ PM Teacher ______________

Has child been seen on our Dental Mobile Unit before? Yes ☐ No ☐ If yes, name of school attending: ______________

Ethnic/Racial Background (Please check all that apply):

☐ African American ☐ Arab/Chaldean ☐ Asian/Pacific Islander ☐ Hispanic ☐ Native American ☐ White

Child of Migrant Farm Worker: Yes ☐ No ☐

## HEALTH HISTORY

| Date of Last Physical Exam: | Date of Last Dental Exam: | Are immunizations Complete? Yes ☐ No ☐ |
|---|---|---|

Medical Doctor's name:

| Question | Yes | No |
|---|---|---|
| 1. Is child under the care of a doctor for any medical condition?<br>If yes, what medical condition? | Yes ☐ | No ☐ |
| 2. Is child taking any medications?<br>If yes, what medications?<br>For what medical condition? | Yes ☐ | No ☐ |
| 3. Is there any abnormal bleeding? | Yes ☐ | No ☐ |
| 4. Has child ever been hospitalized?<br>If yes, for what: | Yes ☐ | No ☐ |
| 5. Has child ever had surgery?<br>If yes, for what? | Yes ☐ | No ☐ |
| 6. Does child have any allergy to penicillin or other drugs?<br>If yes, what allergies? | Yes ☐ | No ☐ |
| 7. Are there other allergies (latex, food, pollen, animals, dust)?<br>If yes, what other allergies? | Yes ☐ | No ☐ |
| 8. Does child have any cognitive or emotional impairments?.<br>If yes, please explain: | Yes ☐ | No ☐ |

9. How do you think child will do with the dental visit?

10. Does the child have any history or difficulty with any of the following? (Please check all that apply)

| | | | | |
|---|---|---|---|---|
| _____ Acid Reflux/GERD | _____ Bladder | _____ Epilepsy | _____ Kidney | _____ Thyroid |
| _____ ADD/ADHD | _____ Cerebral Palsy | _____ Hearing | _____ Liver | _____ Tuberculosis (TB) |
| _____ Anemia | _____ Chronic Sinus | _____ Heart Disease | _____ Mononucleosis | _____ Other: (list below) |
| _____ Artificial Joints | _____ Convulsions | _____ Heart Murmur | _____ Pregnancy | |
| _____ Asthma | _____ Diabetes | _____ Hepatitis | _____ Rheumatic Fever | ______________ |
| _____ Autism | _____ Disability | _____ HIV/AIDS | _____ Steroid Therapy | ______________ |

## AUTHORIZATION

I grant Ottawa County Health Department (OCHD) permission to provide all needed dental services with Nitrous Oxide use, if required, to the above-named minor. I also grant permission for dental, dental hygiene and/or dental assisting students, under the direct supervision of a licensed dental professional, to provide dental services for my child. I understand that an HIV or hepatitis test may be performed on him or her without consent in the event that an OCHD employee or a dental provider sustains a needle stick injury, mucous membrane or open wound exposure to my child's blood or other body fluids. In the event of an emergency I authorize an adult to seek medical attention for my child. I give permission for a school employee to transport my child to OCHD's designated medical facility.

I certify that the above information is true and correct to the best of my knowledge. I hereby authorize OCHD to verify the information above. I understand that if I have given false information this may disqualify my child from receiving dental services. I certify that I give full consent to have my child photographed, videotaped and/or interviewed on "Miles of Smiles" Dental Mobile Unit. I also give full consent for said photographs, videotapes and/or interviews to be published for health agencies use and/or news media releases. Records may be made available to schools, head start programs, dental offices, clinics, health agencies, assistance programs and your health insurance plan, upon request. I have been informed that the HIPAA Privacy Notice is available on the county website www.miOttawa.org/health, Dental Services and click on the Miles of Smiles application. A copy of the HIPAA Privacy Notice is also available upon request by calling 616.393.5771.

| Signature of parent or guardian | Relationship | Date |
|---|---|---|
| | | |



**Información en Español dele vuelta a la pagina**

# Privacy Notice

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Understanding the Type of Information We Have** We get information about you when you enroll in a health plan, or use our healthcare services. The information we receive includes your date of birth, ID number(s) and other personal information.

**Our Privacy Commitment To You** The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and the legal right may see your information. Unless you give us permission in writing, we will only disclose your information for:

**Treatment** We may disclose medical information about you to coordinate your health care.

**Payment** We may use and disclose information so the care you get can be properly billed and paid for.

**Healthcare/Business Operations** We may use and disclose information in connection with our healthcare/ business operations.

**Exceptions** For certain kinds of records, your permission may be needed to release information for treatment, payment and healthcare/business operations.

**As Required By Law** We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety, or in other kinds of emergencies.

**Michigan's Dental Patient Consent Law** We are required by Michigan Law to obtain your written consent prior to making certain disclosures of your health information.

**With Your Permission** In addition to our use of your health information for treatment, payment or healthcare/business operations, you may give us written permission to use your health information or to disclose it to anyone for any purpose. If you give us permission, you have the right to change your mind and revoke it. This must also be in writing. We cannot take back any uses or disclosures already made with your permission.

# Your Privacy Rights

**You have the following rights regarding the health information that we have about you:**

**Your Right to Inspect and Copy** In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.

**Your Right to Amend** You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.

**Your Right to a List of Disclosures** You have a right to ask for a list of disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or healthcare/ business operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.

**Your Right to Request Restrictions on Our Use or Disclosure of Information** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.

**Your request regarding the health information that we have about you must be made in writing to:**

**Privacy Officer**
**Ottawa County Health Department**
**12251 James Street, Suite 400**
**Holland, MI 49424**

# Changes to this Notice

We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website:

**http://www.co.ottawa.mi.us**

To request an expanded version of this notice please contact:

**Corporation Counsel**
**12220 Fillmore, Suite 331**
**West Olive, MI 49460**
**(616) 738-4865**
**(800) 764-4111**

# How To Use Your Rights Under This Notice

If you want to use your rights under this notice, you may call us or write to us. We will help you prepare your written request, if you wish.

**Complaints to the Federal Government.** If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

**Office of Civil Rights**
**Department of Health & Human Services**
**200 Independence Avenue, S.W.**
**Washington, D.C. 20201**
**Phone: (866) 627-7748**
**TTY: (866) 788-4989**
**Email: ocrprivacy@hhs.gov**

You will not be penalized for filing a complaint with the federal government.

**Complaints and Communications to us**. If you want to exercise your rights under this notice, communicate with us about privacy issues or if you wish to file a complaint, you can write to:

**Corporation Counsel**
**12220 Fillmore, Suite 331**
**West Olive, MI 49460**
**Phone: (616) 738-4865**
**(800) 764-4111**

You will not be penalized for filing a complaint.

# Copies of this Notice

You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy:

**Privacy Officer**
**Ottawa County Health Department**
**12251 James Street**
**Suite 400**
**Holland, MI 49424**
**(616) 396-5266**
**(800) 764-4111**

**Ottawa County**
**Health Department**
12251 James Street
Suite 400
Holland, MI 49424
Phone: (800) 764-4111
Fax: (616) 393-5643
http://www.co.ottawa.mi.us

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# Ottawa County Health Department

# HIPAA Privacy Notice

(Condensed Version)

Effective April 14, 2003