THE SEAL INDIANA DENTAL SEALANT PROGRAM IS COMING TO YOUR CHILD’S SCHOOL

WHAT WILL THE SEALANT PROGRAM DO?

Seal Indiana will examine your child’s teeth and perform the following preventive dental services, as needed: as many sealants on permanent teeth as your child needs, a fluoride varnish treatment, a tooth brush cleaning, oral health education and/or temporary fillings.

A **dental sealant** is a plastic material that is applied to the chewing surface of back teeth where decay occurs most often. Sealants protect these teeth from plaque and acid that causes decay. Receiving sealants is comfortable, and no anesthetic is required.

A **fluoride varnish treatment** provides added protection against decay for all teeth. However, this will not be provided if the child is allergic to resins or pine nuts.

A **temporary filling** consist of cleaning the decay in the tooth and placing a temporary restoration.

DOES MY CHILD QUALIFY?

Your child can take part in this program if your child does NOT already see a dentist at least once a year.

To have your child participate, you must complete the form on the inside right page and return it to school within one week.

If you have questions, call (317) 278-0750.

HOW MUCH WILL IT COST?

After your child is treated, you will receive a report from Seal Indiana, stating what services were provided and the amount you, Medicaid, Hoosier Healthwise, or your insurance will be billed.

**OPTION 1: MEDICAID & HOOSIER HEALTHWISE**

100% of the fees will be paid.

For information about free dental and medical insurance for children, call Indiana Hoosier Healthwise: 1.800.889.9949.

**OPTION 2: REQUEST FREE CARE**

Only available if you do NOT have insurance and cannot afford to pay.

**OPTION 3: PRIVATE INSURANCE**

Your insurance will be charged.

**OPTION 4: PAY OUT OF POCKET**

Fees will be charged based on income (see chart).

<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>Students 11 &amp; Younger</th>
<th>Students 12 &amp; Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $18,000</td>
<td>$70</td>
<td>$100</td>
</tr>
<tr>
<td>$18,000 to $22,999</td>
<td>$80</td>
<td>$110</td>
</tr>
<tr>
<td>$23,000 to $27,999</td>
<td>$90</td>
<td>$120</td>
</tr>
<tr>
<td>$28,000 to $36,000</td>
<td>$100</td>
<td>$130</td>
</tr>
<tr>
<td>More than $36,000</td>
<td>$110</td>
<td>$140</td>
</tr>
</tbody>
</table>

*These fees cover all services provided and may be less than shown above, but will not be more.*
INDIANA UNIVERSITY SCHOOL OF DENTISTRY NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY.

1. Purpose: The Indiana University School of Dentistry follows the privacy practices described in this Notice. For purposes of this Notice, the Indiana University School of Dentistry is defined as all professional staff, employees, trainees and volunteers who perform services at a number of treatment sites including the Indiana University School of Dentistry Predoctoral, Graduate, Graduate Dental Hygiene, and Research Clinics, Cottage Corner Dental Clinic, Grassy Creek Dental Clinic, Regenstrief Dental Clinics, University Hospital Dental Clinics, Oral Health Research Institute, Walker Plaza, Seal Indiana: IUSD Mobile Sealant Program (hereinafter IUSD). IUSD maintains your health information in records that will be maintained in a confidential manner, as required by law. However, IUSD must use and disclose your health information to the extent necessary to provide you with quality health care. For example, this, IUSD must share your health information as necessary for treatment, payment and health care operations. This Notice will remain in effect until we replace it. The terms of this Notice may change at any time. You will be notified of such a change in the Notice. Information we maintain in our records before the implementation of this Notice will be used and disclosed only in accordance with the privacy notice we previously provided to you.

2. What are Treatment, Payment, and Health Care Operations? Treatment, includes sharing information among health care providers involved in your care. For example, your physician or dentist may share information about your condition with the pharmacist to discuss appropriate medications; or with radiologists and other consultants in order to make a diagnosis. IUSD will also disclose health information to physicians or other healthcare providers who may be treating you. IUSD may use your health information as required by your insurer or guarantor of payment to obtain payment for your treatment and/or hospital stay. We also use information to improve the quality of care (health care operations); e.g., for review and training purposes.

3. How Will IUSD Use My Health Information? IUSD may use or disclose your health information for the following purposes:
   • Those involved in your care or payment: family members or close friends involved in your treatment.
   • Business Associates: We contract with outside organizations, called business associates, to perform some of our operational tasks on our behalf. Examples would include billing agencies or a copy service which may make copies of your health record. When these services are performed, we disclose the necessary health information to these companies. To protect your health information, however, we require the business associate to appropriately safeguard your information.
   • Disaster relief agency, if you are involved in a disaster relief effort.
   • Appointments as part of normal messages, e-mails, text, postcards or letters.
   • Marketing: To inform you of possible treatment alternatives, benefits or services related to your health. (You will have an opportunity to refuse to receive this information.) IUSD must obtain an authorization from you for certain uses and disclosures of your information for marketing. IUSD will not sell your information for any purpose without your authorization.
   • As required by law: we will disclose your health information when we are required to do so by federal, state or local law.
   • Public health activities: including disease prevention, injury or disability; reporting births and deaths, reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence.
   • Health oversight activities such as audits, inspections, investigations, and licensure.
   • Lawsuits and discovery: If you are involved in a lawsuit or in a court or administrative order, IUSD may disclose health information about you in response to a subpoena or other lawful process by someone else involved in the dispute.
   • Law enforcement: for example, in response to a court order or a law enforcement official process; to locate or identify an individual being sought by authorities; about the victim of a crime under restricted circumstances, e.g., a death that may be the result of criminal conduct; about criminal conduct that occurred on IUSD premises; and in emergency circumstances relating to reporting information about a crime.
   • Coroners, medical examiners, and funeral directors.
   • Organ and tissue donors.

4. Your Authorization is Required for Other Disclosures. Except as described above in this Notice we will not use or disclose your health information unless you authorize (permit) IUSD in writing to disclose your information. Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time and it will be effective upon our receipt of the written revocation.

5. You Have Rights Regarding Your Health Information. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by IUSD:
   • Right to request restriction. You may request that we not use or disclose protected health information for the following purposes:
   - Use or disclosure to health care operations.
   - Use and disclosure of protected health information to researchers involved in your care.
   - Use and disclosure of your health information to third parties for payment or health care operations.
   - Use and disclosure of your health information to any third party to fundraise for the hospital.
   - Use and disclosure of your health information to perform research projects.
   - Use and disclosure of your health information to report information about a crime.
   - Use and disclosure of your health information to report information about a death that may be the result of criminal conduct; about criminal conduct that occurred on IUSD premises; and in emergency circumstances relating to reporting information about a crime.

6. You Have the Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information regarding decisions about your care including mental health notes, however, mental health records may be withheld if the health care provider determines, in their best judgment, that the information is detrimental to the physical and mental health of the patient, or likely to cause the patient to harm himself or another person. Upon request and reasonable notice, you may request access and/or copies by using the contact information at the end of this Notice. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by IUSD; IUSD will comply with the outcome of the review.

7. Complaints. If you believe your privacy rights have been violated, you may file a complaint with IUSD or with the Office for Civil Rights, U.S. Department of Health and Human Services (www.hhs.gov). All complaints must be submitted in writing. You will not be penalized or retaliated against in any way for making a complaint to IUSD or the Department of Health and Human Services.

8. Acknowledgement of Receipt of this Notice. IUSD requests that you sign a separate form acknowledging that you have received a copy of this Notice for review. If you do not wish to sign the acknowledgment or you are not capable of signing, a staffing member will record this fact for you. This acknowledgement will be filed with your records.
I have received a copy of the Indiana University School of Dentistry Notice of Privacy Practices.

My relationship to the patient who is a minor/child is:  

☐ Parent  ☐ Legal guardian  ☐ Other ______________________________

Signature __________________________ Date ____________________

GENERAL INFORMATION & CONSENT FOR TREATMENT

Child’s Name __________________________ FIRST MIDDLE INITIAL LAST

Date of Birth __________________________ Age ________ Sex: M F School name ______________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Prefer not to answer

☐ Asian ☐ White ☐ Prefer not to answer

☐ Black ☐ Other ☐ Prefer not to answer

Is your child allergic to latex, resin or pine nuts? ☐ Yes ☐ No If yes, please specify ______________________________

Does your child have asthma? ☐ Yes ☐ No

Briefly explain any health issues your child has and/or list medications your child is taking: ______________________________

Does your child need medication before having dental treatment? ☐ Yes ☐ No

Parent/Guardian Name __________________________ Relationship to child __________________________

Address __________________________ Phone # __________________________

STREET CITY ZIP CODE

I give Indiana University School of Dentistry (IUSD) permission to provide preventive dental services for my child at this first visit and a follow up visit. Preventive dental services may include dental examination, dental sealants on permanent teeth, fluoride varnish treatment and/or temporary fillings. I give IUSD permission to collect payment from Medicaid, Hoosier Healthwise or insurance on my behalf, and to allow the nurse and the dentist of my choice to obtain my child’s dental record from this examination. I understand that if my child is not enrolled in Medicaid/Hoosier Healthwise, a fee will be charged based on my Statement of Ability to Pay. By signing below, I am indicating that I have read and understand the services that will be provided, that I understand the terms of the consent agreement, and that I have the legal authority to give this consent on behalf of the child.

Signature __________________________ Date ____________________

STATEMENT OF ABILITY TO PAY

OPTION 1  Medicaid & Hoosier Healthwise  Child’s 12-digit Medicaid Recipient ID: __________________________

Medicaid and Hoosier Healthwise pay 100% of services. If your child is enrolled in Medicaid or Hoosier Healthwise but has other insurance that must be used first, you must also fill out the Insurance Section (Option 3 below).

OPTION 2  Request free care  ☐ I have no insurance and I cannot afford to pay. I request free preventive care and sealants for my child

OPTION 3  Private Insurance  Name of insured __________________________ Employer __________________________

Insured date of birth __________________________ Relationship to child __________________________

Insurance company __________________________

ID# __________________________ Group # __________________________

OPTION 4  Pay out of pocket  I will expect to receive a bill for my child’s dental treatment, according to my annual income level checked below (if unchecked, the middle category will be used to determine the fee).

☐ More than $36,000  ☐ $23,000 - $27,999  ☐ Less than $18,000

☐ $28,000 - $36,000  ☐ $18,000 - $22,999
THANK YOU FOR TAKING THE TIME TO CONSIDER SEAL INDIANA FOR HELPING YOU PROTECT YOUR CHILD’S TEETH

RETURN THIS FORM WITHIN ONE WEEK TO PARTICIPATE