

Kenton County School District | *It's about ALL kids.*

**THE KENTON COUNTY BOARD OF
EDUCATION**

1055 EATON DRIVE, FORT WRIGHT, KENTUCKY
41017

TELEPHONE: (859) 344-8888 / FAX: (859) 344-1531

WEBSITE: www.kenton.kyschools.us

Dr. Henry Webb, Superintendent of Schools

KCSD ISSUE PAPER

DATE:

January 28, 2019

AGENDA ITEM (ACTION ITEM):

Consider/Approve A participation agreement with *NKY Independent Health Department* to offer dental services to our students, during the school day, as coordinated through the Family Resource Center or Health Services Dept. and approved by the school principal.

APPLICABLE BOARD POLICY:

01.1 Legal Status of the Board

HISTORY/BACKGROUND:

Each year, 55 million school hours are lost due to improper dental care. NKY Independent Health Department provides dental sealants and screenings to students to reduce this barrier to student achievement by bringing dental care to the school. By offering dental care at school, our students have the opportunity to receive the services they need with a reduction in missed instructional time during the school day. The services are coordinated by the Family Resource Center Coordinator or School Nurse and approved by the principal. Parents give permission for the student to participate in the program. Additional information provided to the parents about the program and the permission slip are attached.

FISCAL/BUDGETARY IMPACT:

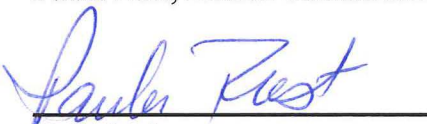
\$0.00 at the district level

RECOMMENDATION:

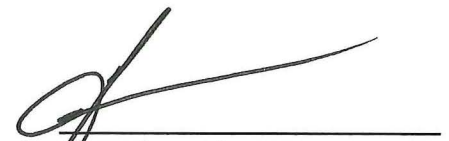
Approval to enter into a participation agreement with the NKY Independent Health Department to provide a dental program and dental services with parent permission for all schools who choose to schedule their services.

CONTACT PERSON:

Paula Rust, Health Coordinator


Principal


District Administrator


Superintendent

Use this form to submit your request to the Superintendent for items to be added to the Board Meeting Agenda.

Principal –complete, print, sign and send to your Director. Director –if approved, sign and put in the Superintendent’s mailbox.

Kenton County Board of Education

Board Members: Carl Wicklund, Chairperson Karen L. Collins, Vice Chairperson Carla Egan Shannon Herold Jessica Jehn
“The Kenton County Board of Education provides *Equal Education & Employment Opportunities.*”



NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT



2018-2019 Dental Program School – NKIDHD

Responsibilities

Eligibility of School

- Schools must have 50% or more of the enrolled students participating in the Free and Reduced Lunch Program.

Education/Presentation

- A presentation will be conducted by a Dental Health Professional 4-6 weeks prior to the program coming to your school.
- The presentation will last approximately 20 minutes.
- 2 presentations may be needed if the number of students is too large for 1 presentation
- Consent forms will be provided to the homeroom teachers to be distributed to the students

Consent Forms

- Enough consent form packets will be provided to the school for each student in the participating grades.
- A Master File folder will be given to each school contact person at the presentation. These master forms are to be used by the school to make additional copies, if needed.
- Students must return the completed consent forms in order to participate in the program
- Consent forms will be picked up by Health Department Dental Staff 1 week prior to the dental program beginning.
- **School personnel must check forms to make sure the following is complete:**
 - **Parents have signed in the appropriate spots on the consent form**
 - **Social Security #, Medicaid #**
 - **Date of Birth and Medical History**

Equipment

- Equipment will be delivered by the Health Department 1-2 days prior to the dental program.
- Equipment should be placed in the area that has been designated for the dental program.
- The location must be clean and secure and have adequate space

Professional Staff

- A Public Health Dental Hygienist will conduct an oral health screening, apply the dental sealants, perform a dental cleaning, and apply fluoride on the students whose parents have consented.
- A Dental Assistant will set-up and break-down dental equipment, pull students for the dental screenings, sterilize instruments and assist the Public Health Dental Hygienist.

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Schools Responsibility

- **Provide internet access via direct plug in if possible, or by wireless connection.**
- Provide clean, secure space with access to electrical outlets
- 1 table and 2 chairs
- Distributing and collecting forms
- Parent follow up regarding student's oral health at request of the NKHD
- Reporting to the NKHD the status of students referred for decay
- Keeping a list of area dentists and the Medicaid/MCO's they belong to in order to assist parent in finding dental care for their child.

Promotion of the Program:

Each school is required to promote the dental program in their schools in at least one of these ways:

- **Announcement of program on their website, facebook, twitter 1-2 weeks prior to the event.**
- **Include the dates in the school calendar**
- **Class/Grade/School Newsletters**
- **All Calls or Emails to the parents**
- **Distribution to parents and within the schools of the reminders that the NKHD provide.**

Other Dental Programs in your school:

The NKHD requests notice prior to us visiting your school if other portable/mobile dental programs are scheduled to provide services during the school year. We do not want to duplicate services or confuse the parent with differing consent forms.

Fees

- The Health Department will bill Medicaid for services provided.
- Students with Private or No Insurance will be charged a sliding fee per dental assessment, dental sealant, dental cleaning, and fluoride based on household size and income as mandated by the state of Kentucky. **Grant funding has been made available that reduces the maximum charge to only \$10 per service.**

Linda Poynter, RDH, BHS; 859-363-2035; fax: 859-578-3689; linda.poynter@nkyhealth.org
8001 Veterans Memorial Dr., Florence, KY 41042



NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT



Dental Prevention Program

2018-2019 School Participation Form and Agreement

By returning this form you are stating that your school is interested in participating in the dental prevention program and that you will abide by the contents of this and the accompanying

Date: _____

School Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Principal's Name: _____

Contact Person: _____ Email: _____

Job Title: _____ Phone Number: _____

Number of students: Pre K ____ K ____ 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____ 6th ____

____ Number of total students at the school. ____ The grades that are presently enrolled in your school.

____ Current Free and Reduced Lunch Percentage.

____ Earliest time of day the dental program can begin.

Are other dental mobile programs scheduling for your school? ____ If yes, when? ____

Please be aware we may not be able to service your school if outside groups are planned. Please call me to discuss further.

Your signature signifies that your school will do the following promotional activities in order to reach and educate the parents about the oral health program available:

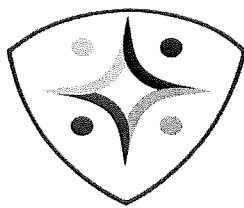
- Announcement of dental program on your website, facebook, twitter
- Include the dates on the school calendar for parents to see
- Class/Grade/School Newsletters
- Distribution of reminders that the NKHD will provide both to parents and within the school

School contact's signature here is an agreement to abide by the contents of the accompanying Agreement, including promotion of the program and decay follow-ups. This form is also an agreement by the NKHD to abide by the same contents:

____ Title: _____

Please return this form by mail, email or fax to:

Linda.Poynter , RDH, BHS
linda.poynter@nkyhealth.org
Phone: 859.363.2035 Fax: 859.578.3689



NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT



TO: Teachers, School Nurse, FRYSC, Staff

The Northern Kentucky Health Department's **Dental Prevention Program** is scheduled to be at your school this year.

WHAT DENTAL SERVICES ARE AVAILABLE?

Pre K: Dental assessment, fluoride varnish, and Dental Screening Form

Kindergarten: Dental assessment, fluoride varnish, dental cleaning and Dental Screening form.

All other grades: Dental assessment, fluoride varnish, dental cleaning, and dental sealants as needed

HOW DO THE CHILDREN LEARN ABOUT THE DENTAL SERVICES?

Our dental hygienist does a presentation 2-4 weeks before our visit for the 2nd grade students. She shows a five-minute video, which describes why sealants are used and how they are applied. The teachers of students in the other grades are asked to show the DVD or video on flash drive for their students.

HOW WILL THIS AFFECT MY CLASS?

Classroom participation in oral health education is a critical component of the Dental Prevention Program. A tooth model, relevant handouts and a curriculum, DVDs and books courtesy of the NKHD are available from your school nurse or FRYSC and should be used for classroom instruction to augment the actual sealant placements. While the program is in your school, participating children will be taken from class first for approximately 15-20 minutes each.

DOES THE PROCESS HURT?

The dental processes are painless and require no shots. Students should not experience discomfort when they return to class, although the first day they may feel as though they are biting on something.

WHAT DOES IT COST?

There is no cost to those who are covered by Medicaid. The costs for those with no dental coverage will be determined by family size and income. **Sliding fees and grant money for non Medicaid and privately insured students allows the cost to be from \$0 to a max of \$10 per service.** We do not file private insurance but are happy to see those children under the previous conditions. Please see the cover letter attached to the consent form for complete fee listings.

WHAT IS EXPECTED OF TEACHERS AND HEALTH STAFF?

Your assistance in getting consent forms returned from every child in your class is critical to our ability to prevent a lifetime of dental disease. Please remind students frequently to return the forms, and check to see that the form is completed. Promotion of the program on the school's website, calendars, facebook and twitter pages, and all calls are an expectation of the school's participation in this program. Health staff will be given a folder that will enable you to make more copies if needed, or call Linda at the number below. A \$25 gift card is given to a class that returns 100% of the forms with at least 50% of them "yes". Those teachers' names are then eligible for a gift basket at year's end.

If you have any questions or recommendations about this program, you may call Linda Poynter, Oral Health Program Manager at 859-363-2035, email linda.poynter@nkyhealth.org, or ask the dental hygienist on site. Thank you for your continuing support of this program.

Low cost or no cost *Dental Services* at your child's school

WHAT

A **dental screening** is done by a licensed dental hygienist from the Health Department.

Dental cleanings remove bacteria from the teeth and gums to prevent cavities and gum disease.

Dental sealants are thin, plastic coatings painted on the chewing surfaces of the back teeth to help prevent cavities.

Fluoride varnish makes the outside of all the teeth stronger to help keep cavities from starting.

WHO

Students PreK—6th grade

All students will receive a teeth screening, fluoride varnish to protect all the teeth, a dental cleaning if needed, and a completed Kentucky Dental form for school entrance.

Students grades 1-6 will ALSO receive dental sealants on their permanent molars if needed.

All students receive instruction in the care of their teeth, follow up, and a referral to your dentist.

WHY

Cavities are the most common disease in children. 40% of the children seen in the program have cavities, many of which are urgent. Children cannot learn, pay attention or eat when they have cavities.

All children, regardless of insurance or income, should receive dental services.

Since 2004, the Health Department's dental program has provided preventive dental services that are convenient for families. **Our goal is for all children to have a dentist of their own. We are not a replacement for your dentist.**

COST

If your child is covered by Medicaid, the cost of services is billed to Medicaid for payment.

If your child is not covered by Medicaid, services are provided at no or very low cost, based on family size and income outlined in the table below:

We do not accept private dental insurance, but can see your child for the fees below.

Funding from the United Way of Greater Cincinnati, Delta Dental and Kentucky Department for Public Health helps keep program fees low.

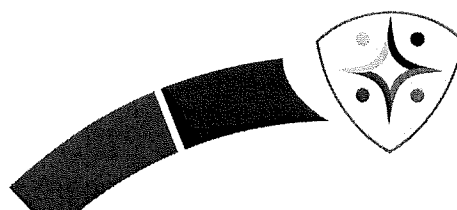
SERVICE	FEE
Screening of the teeth and gums	No charge to a maximum of \$10
Dental cleaning	No charge to a maximum of \$10
Each dental sealant	No charge to a maximum of \$10
Fluoride varnish	No charge to a maximum of \$10

**Start
here**

If you would like your child to participate in the dental program, please fill out BOTH SIDES of the consent form that is attached.

QUESTIONS?

Call Linda at 859-363-2035
or email linda.poynter@nkyhealth.org



NKYHEALTH
NORTHERN KENTUCKY HEALTH DEPARTMENT

SCHOOL DENTAL PROGRAM

Consent Form and Patient Registration

Patient Information: PLEASE PRINT (All items refer to the child for whom you are consenting for dental services.)
If NO dental services are wanted: Circle NO here and print name and grade/teacher only.

CHILD'S NAME: Last _____	First _____	Middle _____	SOCIAL SECURITY # _____
(MAILING) ADDRESS _____	CITY _____	COUNTY _____	STATE _____ ZIP CODE _____
/ / BIRTHDATE _____	SCHOOL _____	GRADE/TEACHER _____	
PARENT/GUARDIAN NAME: _____		RELATIONSHIP TO CHILD: _____	
HOME PHONE _____	OR	CELL PHONE - TEXT? Y or N _____	EMAIL _____

No or Very Low Cost Dental Services Available; see attached letter for explanation of any charges:

Students receive a dental screening, fluoride varnish, and a dental cleaning.

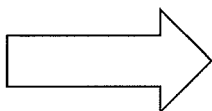
Dental sealants are applied on permanent molars for those who need them (usually over age 6).

This program is not a replacement for your regular dentist.

ALL MUST SIGN - FOR CONSENT FOR DENTAL SERVICES

MUST BE SIGNED FOR CHILD TO BE SEEN!

Of my own free will I consent to dental care which may include dental screening, fluoride, cleaning, and sealants given to minor child by Public Health Dental Hygienists staff or agents of this health department. NKHD Public Health Registered Nurses may provide dental screening and fluoride only. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if a health care worker is exposed to my blood, body fluids or tissue. This form, when signed and filled in, contains Protected Health information and the information is to be protected according to the health Insurance Portability and Accountability ACT (HIPAA). My signature below acknowledges my receipt of Northern Kentucky Independent District Health Department's newly revised "**NOTICE OF PRIVACY PRACTICES**" which is available on www.nkyhealth.org or at your school's office. I understand that no dentist is present for the dental procedures, and the public health dental hygienists are working under the supervision of Jack Lenihan, DMD, and Jonathon Rich, DMD. These services do not take the place of regular dentist visits, and all children will be referred to their own dentist for a full exam. I also understand that my child might receive fluoride 2 times during the school year and may be checked for the retention of any sealants placed during the following school year.

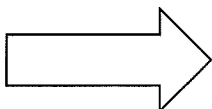


Signature of Parent/Guardian or other Authorized Person
(Expires 1 year from date signed)

Date

ADDITIONAL SIGNATURE IF CHILD HAS MEDICAID

ASSIGNMENT OF BENEFITS: I request that payment of authorized medical insurance benefits be made to Northern Kentucky Health Department on my behalf, for services I received. I also authorize the local health department to release medical information about me to Medicare, Insurance and other third party payors to determine payment for services. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third party payors pursuant to KRS 214.420. I have read the above and have had an opportunity to ask questions. I understand the above statement as it applies to me and my child. My signature below indicates I do consent, authorize or declare as stated.



Signature of Parent/Guardian or other Authorized Person
of child with Medicaid

Date

10 DIGIT MEDICAID NUMBER (WE MUST HAVE NUMBER): _____

Circle your Medicaid type: AETNA WELLCARE PASSPORT HUMANA ANTHEM

****** TURN FORM OVER AND COMPLETE ******



CHILD NAME _____ BIRTHDATE _____

ALL MUST FILL OUT - MEDICAL INFORMATION:

Child's medical doctor: _____ Phone number: _____

Child's dentist: _____ Date of any scheduled dental appointments _____

Date of last dental visit (circle): NEVER LESS THAN 6 MONTHS MORE THAN 6 MONTHS

Does your child have any allergies to food or to medicine (circle)? Yes No If yes, list _____

List ANY medication your child takes (include over the counter medication or herbal medication) _____

Does your child have ANY illnesses, diseases, or conditions including ADHD, asthma, heart conditions, diabetes, contagious diseases? Yes No
Please explain: _____

ALL MUST FILL OUT - DEMOGRAPHICS:

SEX (Check One)

☐ Female

☐ Male

RACE (Check one or more)

☐ W) White

☐ B) Black or African American

☐ N) American Indian or Alaska Native

☐ A) Asian

☐ H) Native Hawaiian or Other Pacific Islander

ETHNICITY (Check One)

☐ Y) Hispanic or Latino

☐ N) Not Hispanic or Latino

ALL MUST FILL OUT – FINANCIALS:

Is your child currently covered by Medicaid? Yes No

Is your child currently covered by private Dental Insurance? Yes No

Is your child enrolled in KTAP? Yes No

Is your child enrolled in the Food Stamp Program (SNAP)? Yes No

We do not accept private dental insurance but can see your child at our low fees based on a sliding scale.

Number of Persons in Household _____ Yearly Household Income \$ _____

(This Information needed to determine charges - Strictly Confidential)

Please return form to your child's classroom teacher, school nurse or family resource person.
Contact Linda Poynter at 859-363-2035 or linda.poynter@nkyhealth.org with any questions.
NKY Health has been providing dental services in our schools for 14 years.