MEMORANDUM OF AGREEMENT
between the
Florida Department of Health
Baker County Health Department
and the
School Board of Clay County, Florida

This Memorandum of Agreement is entered into between the Florida Department of Health, Baker County Health Department, hereinafter referred to as the "Baker CHD", and the School Board of Clay County, Florida, hereinafter referred to as the "School Board", to provide dental services to students in Clay County public schools.

The purpose of the Dental Services Program is to reduce the incidence of dental disease by providing an effective preventive and treatment program. One of the most outstanding unmet needs in public health is that of dental services for the indigent school aged population. The Baker County Health Department Dental Program, in conjunction with School Board, will provide a school based dental care program. This program effectively eliminates the barriers which exist for many families seeking the care of a dentist: transportation problems, lack of information on how often children should be seen for check-ups, and time away from the job.

RIGHTS AND RESPONSIBILITIES

I. Baker CHD agrees:

A. To provide restorative and surgical dental treatment for students referred by the School Board.
B. To provide reports documenting any need for further dental services for students within 30 days of initial service.
C. Dental services will be rendered via mobile unit at multiple schools to be coordinated between Provider and School Board Nursing Supervisor.
D. Services rendered under this agreement are funded by Medicaid. The Baker CHD will be responsible for billing the appropriate agency for reimbursement of services rendered.

II. School Board agrees:

A. To refer students who qualify for Medicaid to the Baker CHD to receive dental services.
B. To distribute the attached forms to parents for students referred for dental services. including Information sheet (Attachment 1), Parental Permission Form (Attachment II), Dental Health History (Attachment III), Dental Services Patient Registration (Attachment IV), Initiation of Services (Attachment V), and a Consent for Services (Attachment VI).
C. To transport students to the service location for dental services.

III. **Both parties agree:**

A. The term for this agreement will be for three (3) years beginning July 1, 2015 and ending on June 30, 2018.

B. That no relationship of employer/employee, principal agent, or other association shall be created by this agreement between the parties or their directors, officers, agents or employees. The parties agree that they will never act or represent that they are acting as an agent of the other, or incur any obligation on the part of the other party.

C. That each party shall be responsible for the liabilities of their respective agents, servants and employees. It is understood that School Board and Baker CHD, and their agents, servants and employees are protected against tort claims as described in Section 768.28, Florida Statutes. Nothing herein is intended to serve as a waiver of sovereign immunity, nor shall anything herein be construed by a state agency or political subdivision of the State of Florida to suit by third parties.

D. The parties shall maintain confidentiality of all protected health information, including records related to the services provided pursuant to this Agreement, in compliance with all applicable state and federal laws, rules and regulations. The parties agree to comply with the Health Insurance Portability and Accountability Act (HIPAA) and any current and future regulations promulgated thereunder, including 45 C.F.R. Parts 160, 162 and 164.

E. Both parties shall insure that their employees have passed a fmgerprint based background screening in accordance with the Jessica Lunsford Act.

F. Either party may terminate this agreement without cause upon thirty (30) days written notice, delivered to the other party by certified mail, return receipt requested, or by hand with proof of delivery.

G. In the event funds to finance this project become unavailable, the provider may terminate this agreement upon no less than twenty-four (24) hours notice in writing to the School Board. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The provider shall be the final authority as to the availability of funds.

H. The contact persons for each party are as follows:

School Board of Clay County, Florida
Donna Wethington, Supervisor of
Student Services
900 Walnut Street
Green Cove Springs, FL 32043
(904) 529-2800 ext. 2869

Baker County Health Department
Samantha Stewart, Contract Manager
480 West Lowder Street
Macclenny, FL 32063
(904) 259-6291 ext. 2236

IN WITNESS THEREOF, the parties hereto have caused this contract to be executed by their undersigned officials as duly authorized.

School Board of Clay County, Florida

_____
Johnna McKinnon
Chairman

_____
Date

Florida Department of Health
Baker County Health Department

_____
Kerry Dunlavey, R.N., M.S.H.A., M.P.H.
Administrator

_____
Date

"Join Our Safari for Healthier Smiles"

BAKER C.A.R.E.S

(County Alliances Rendering Excellent Smiles)

Baker County Dental Bus, in cooperation with the County Health Departments and County School Districts will provide dental treatment to local children and young adults, ages 3-20.

The bus will be parked at your child's school or the health department during the school year.

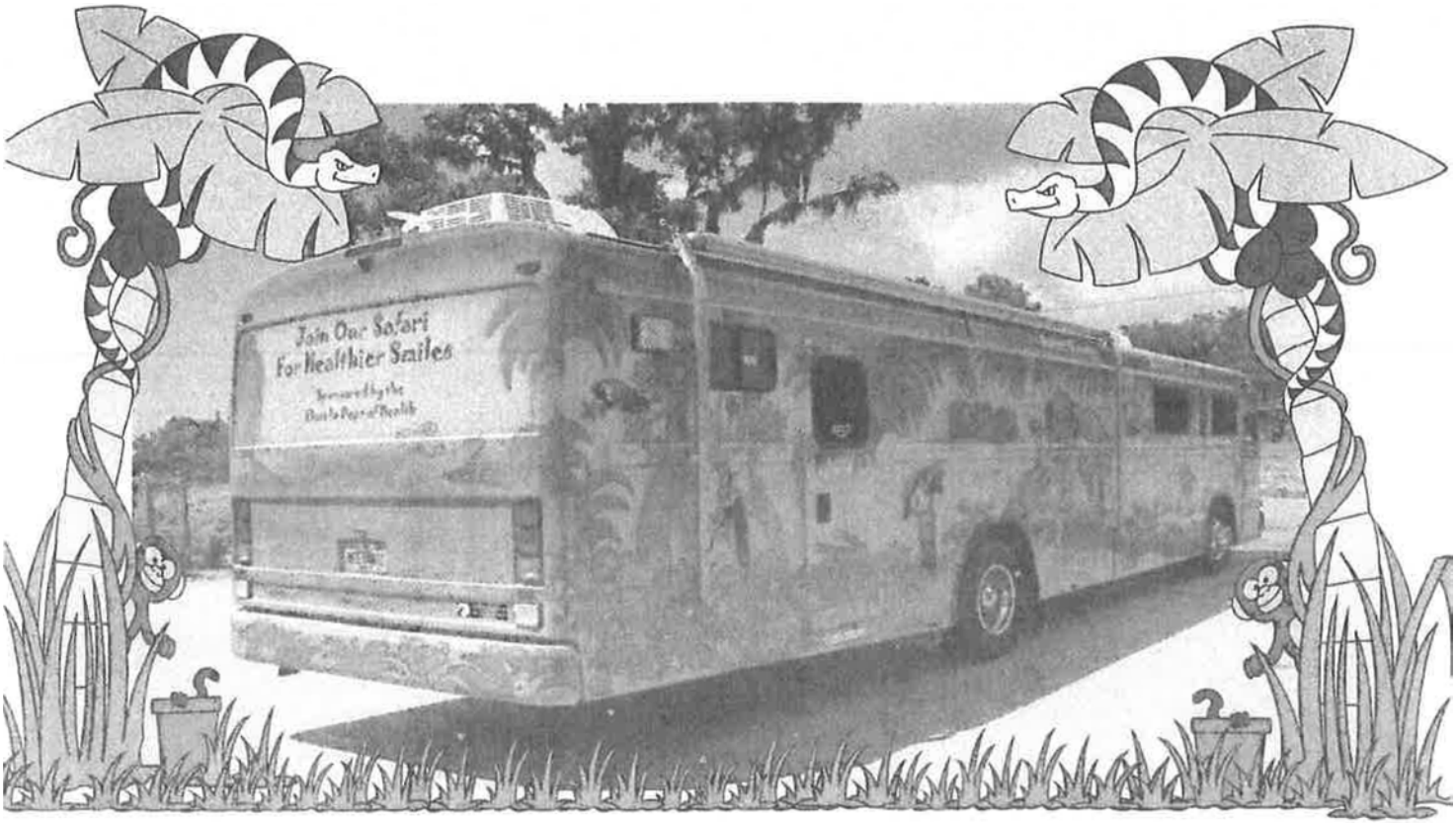
The Dental Bussing Program enables eligible children to be seen during school hours for dental care.

Students who are on **MEDICAID** are eligible for this program. The bus treats children who have Florida Medicaid, CMS, or FL KidCare (Dentaquest or Argus)

Services provided: dental exam/x-rays, cleanings, sealants, fillings and extractions.

If you have any questions, please feel free to contact our office 904-259-6291 or 1-866-617-8708 ext. 2282 or your school nurse.

If **your child has MEDICAID coverage and you wish for them to participate, please fill out the attached medical history and permission slip and return them to your child's school nurse.**



Mission:
To protect, promote & improve the health of all people in Florida through integrated stale, county & community efforts.

Florida HEALTH Baker County

Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State In the Nation

BAKER C.A.R.E.S.

(County Alliances Rendering Excellent Smiles)

The Baker C.A.R.E.S. Children's Dental Bus is looking forward to coming to your child's community. The Baker County Health Department in cooperation with your local Health Department and School Board will provide dental services to children on MEDICAID. Services provided: dental exams/x-rays, cleanings, sealants, fillings and extractions. Parents who wish to have their children participate should sign the permission slip below and fill out the medical history packet attached. Please return all papers to your school nurse or to the Baker County Health Department-Dental Clinic.

PLEASE NOTE: Your child will not be scheduled for a dental visit until the health history package is received and eligibility is verified. Please fill out the packet LEGIBILY and NEATLY. BE SURE TO SIGN ALL PAGES AND DO NOT LEAVE ANY BLANK SPACES or QUESTIONS UNANSWERED; this will delay your child's care while papers are being returned to you for completion.

****RETURN BY October 31st***

Not all eligible children will be served due to limitations in the number of appointments. We will attempt to provide as much care as our time and resources allow.

If you have any questions, please feel free to contact our office 904-259-6291 or 1-866-617-8708 ext. 2282 or your school nurse.

PLEASE PRINT CLEARLY

I give my permission for my child _____ Date of Birth _____

Mailing Address _____

Phone Number (daytime) ( ) _____

Name of school child attends _____ Grade _____

Teacher _____, to participate in the Baker County Health Department Dental Outreach Program. I also give permission for my child to receive x-rays, local anesthesia and dental treatment which includes cleanings, fillings, and extractions (tooth removal) as well as any pre or post-op medications that the dentist feels are appropriate.

_____ _____

Parent or Guardian Signature Date

_____ _____

Printed Name (same as above) County

Dental Health History

Name _____
ID No. _____
Birth Date.. _____

In the following questions, circle Yes or No, whichever applies. Your answers will be considered confidential.

I. Do you (PATIENT) have or have you (PATIENT) had any of the following:

Rheumatic Fever or Heart Munnur	Yes	No	Neurological Problems	Yes	No
Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
Anemia or Blood Problems	Yes	No	Liver Problems or Hepatitis	Yes	No
Sickle Cell Anemia	Yes	No	Venereal Disease	Yes	No
Excessive Bleeding or Bruise Easily	Yes	No	AIDS/ARCIHN Positive	Yes	No
Blood Transfusions	Yes	No	Cancer	Yes	No
Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Trimester I 2 3		
Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
Emotional Problems	Yes	No	Other _____	Yes	No

2. Are you (PATIENT) currently under the care of a physician (doctor)? Yes No
   If yes, list name of doctor.

3. Have you (PATIENT) been hospitalized in the last 2 years? Yes No
   lfyes, why? _____

4. Are you (PATIENT) currently taking any medications, pills or drugs? Yes No
   If yes, list. _____

5. Are you (PATIENT) allergic to or have you ever experienced any ill effect from a local anesthetic (novocain), penicillin, or any drugs/pills? i.e., rash, itching or fainting. Yes No
   lfyes,descrlbe. _____

6. Have you (PATIENT) ever experienced any unfavorable reaction from previous dental treatment? Yes No
   If yes, describe. _____

1. Are you (PATIENT) currently having any dental pain or problem? Yes No
   If yes, describe. _____

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature ofPatient _____ Date _____
(If patient is a child, parent or legal guardian must sign) Relationship _____

Comments by Dentist: _____

Signature of Dentist _____ Date _____

Attachment 4

BAI(ER COUNTY HEALTH DEPARTMENT
DENTAL PATIENT REGISTRATION

NOTE: THIS FORM IS REQUIRED BEFORE YOUR CHILD CAN BE TREATED!

PLEASE PRINT

PATIENT NAME
FIRST: M.INITIAL: LAST:

PhysicalAddress: CITY ZIP

Mailing Address

Phone Number — — — — — — Cell Number----— — School _____ Grade _____

PATIENT'S SocialSecurity Number---— — — — — — — — — — — — Race _____ SeX= — —

Patient's Birthdate:— — — — — — —

Patient on Medicaid (Y OR N): — — — — — Medicaid## —

Father's Income----— — — — Yr,Month,Week, BW Employer _____

Mother's Income — — — — — — — — Yr,Month,Week, BW Employer---— — — — — — — — — — — —

Caregiver's Income-— — — — — — Yr,Month,Week, BW Employer — — — — — — — — — — — — —

SSI:_____ AFDC:_____ ALIMONY: — — — — — CHILD SUPPORT:— — — — —

UNEMPLOYMENT:— — — — — WORKERS COMP:---------INCOME: OTHER UNEARNED _____

PLEASE LIST EVERYONE THAT LIVES IN THE HOUSEHOLD;

NAME			BACE/SEX	BELATIONSHIP TO PATIENT
1. — — — — — — — — — — —				
2. — — — — — — — — — — —				
3. — — — — — — — — — — —				
4. — — — — — — — — — — —				
5. — — — — — — — — — — —				
6. — — — — — — — — — — —				
7. — — — — — — — — — — —				
8. — — — — — — — — — — —				

PARENT/GUARDIAN SIGNATURE---— — — — — — — — — — — — — — — DATE---— — — — — —

Revised 04/09

Florida HEALTH Baker County

INITIATION OF SERVICES

fABI..! CLIENT-PROVIDER RELATIONSHIP CONSENT

CllentName= ———————— ——————————————————————————————

——————— Name or Agency: Baker County Health Department

Agency Address: 480 West Lowder Street. Macclenny, FL 32063

I consent to entering Into a client-provider relationship.I authorize Department or Health staff and their representatives to render routine health care. I understand routine health care Is conftdentlal and voluntary and may Involve medical omce visits including obtaining medical history, examination, admlnl.stration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; Including medleal, dental, HIV/AIDS,STD,TB,substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST
(Only applies to Medicare Clients)

As Client/Representative signed below, I certll)r that the Information given by me In applying for payment under Title XVIII of the Social Security Ad is correct. I authorize the above agency to release my medical Information to the Soelal Security Administration or Its Intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized beneftts be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize It to submit a claim to Medicare for payment.

PART IY ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client/Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy.The amount or such beneftts shall not exceed the medical charges set forth by the approved fee schedule.All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

fA.RI..Y MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature ____ Self or Representative's Relationship to Client ____ Date ____

Witness (optional) ____ Date ____

PART VI WITHDRAWAL OF CONSENT

I, ____________________ WITHDRAW THIS CONSENT, effective ____________
Client/Representative Signature Date

Witness (optional) ____ Date ____

Client Nome; ________________________

10#= ____________

DOB: ____________

Patient Name: _____

BAKER COUNTY HEALTH DEPARTMENT
CONSENT FOR SERVICES

NOTE: THIS FORM IS REQUIRED BEFORE YOU OR YOUR CHILD CAN BE TREATED

Whenever medical or dental treatment is performed there is always the risk of complications due to unexpected problems. In dentistry some of the risks include, but are not limited to: allergic reaction to the drugs and medicines used, excessive bleeding, temporary or permanent numbness, fracture of the jaw, post-operative pain or joint pain. Frequently, children who are experiencing a lip that is asleep from anesthetic will chew on their lip. If your child does this, do not worry as it will heal quickly and without a scar. The occurrence of these is rare, but you should know that they do occur.

I have read, understand and accept the above risks. I give my consent for the recommended procedures.

I consent to have released to the dental program any medical chart, or information concerning the patient's physical or psychological condition, from any source to be used to provide the best dental care possible.

Patient/ Guardian
Signanrre: _____

Date: _____