

WHITESIDE
 COUNTY
HEALTH
DEPARTMENT

Main Office: 1300 W. 2nd St.
Rock Falls, IL 61071
Phone: 815-626-2230
Fax: 815-626-2231

Environmental Office: 18819 Lincoln Rd.
Morrison, IL 61270
Phone: 815-772-7411
Fax: 815-772-4723

Greetings to all of our School Nurses,

The Whiteside County Health Department Dental Clinic will once again offer the Dental Sealant Program to our area schools for the 2019-2020 school year. The State of Illinois Sealant Grant will cover the cost of the treatment for second and sixth graders if they do not have Illinois Public Aid or private dental insurance.

We do offer the services to kindergarten through eighth grade students. This service is offered for a fee of \$40.00 if the student does not have Illinois Public Aid or private dental insurance.

We do have a few changes to our policy for the 2019-2020 school year.

If the student does not have Illinois Public Aid or private insurance, and is not a second grade or sixth grade student, the payment of \$40.00 must be sent with the sealant program paperwork. If the student has private dental insurance, a copy of the insurance card must be included in the sealant paperwork.

*This is also
open to pre-school
and
9th
Graders*

Finally, we have some wonderful gifts to giveaway this school year to the School Nurses who recruit the most students for this program. We look forward to working with all of you and we appreciate all you do to help your students maintain a healthy smile.

Sincerely,

Dr. Monica Wilwert DDS, Whiteside County Dental Director

Jana Meiners, Whiteside County Dental Clinic Supervisor
(815) 626-2230 Ext. 1204

Melissa Johnson, Sealant Program Coordinator
(815) 626-2230 Ext. 1255

*This clinic will be
March 17 & 18th.
L. Rogis RN*



WCHD School Dental Clinic Program
 Permission Form
 2019-2020

1300 W. 2nd St.
 Rock Falls, IL 61071
 (815) 626-2230

If you would like your child to participate in the school dental clinic, please complete this form and return to your school nurse.

A quality public health dental clinic is coming to school! Our school exam fulfills the state law requiring all K, 2nd, and 6th graders to have a mandatory dental exam. This program prevents tooth decay by providing exams, cleanings, fluoride and sealants (a protective coating on the chewing surfaces of the back teeth) to children in need of dental care. A referral may be made to the Whiteside County Community Health Clinic in Rock Falls for follow-up dental care, if needed. A discounted fee of \$40 may be available, depending on income (see chart on back). Medicaid/All Kids, insurance, and private pay is accepted. **All insurance information must be completed or full-fee will be charged. Any balance unpaid by insurance will be charged to the parent/guardian.** Thank you for helping us to promote oral health for children.

PLEASE CIRCLE OR WRITE-IN THE APPROPRIATE ANSWER:											
Child's Name:				Grade:		Teacher:		Birthdate: / /			
Address:				City:		Zip:		Male or Female			
County:		Phone:		Emergency Contact (Relationship):			Phone:				
Ethnicity:		Hispanic		Non-Hispanic		Race:		White			
								African American			
								Native American			
								Asian/Pacific Islander			
								Other: _____			
When was your child's last dental visit?				Dentist:		For what service?					
MEDICAL INFORMATION:											
Has child complained of dental problems?				YES		NO		If YES, what?			
List all known allergies:											
Has your child ever had any of the following? If YES, please circle:				Epilepsy		Currently has Heart Murmur		Latex Allergy		Diabetes	
Seizures		Hepatitis		Anemia		Bleeding Disorders		Cancer		Thyroid Rheumatic Fever or Rheumatic Heart Disease	
Other medical conditions (please list):											
Is your child taking any medications? If YES, please list:											
PAYMENT INFORMATION: (please mark payer source and complete chart on back, if applicable)											
<ul style="list-style-type: none"> • ALL insurance information must be completed or full-fee will be charged. • ANY BALANCE UNPAID BY INSURANCE WILL BE CHARGED TO THE PARENT/GUARDIAN. 											
No Dental Insurance or ILLINOIS Medicaid / All Kids: (see chart on back for discounted fee eligibility)											
ILLINOIS Medicaid / All Kids: Provide Child ID #:											
Private Dental Insurance Company Name:											
Insurance Company's Address:					Insurance Co's Phone #:						
Insured's SSN or ID#:					Group #:						
Insured's Name:					Insured's Employer:						
Insured's Birthdate: / /			Address:			Phone:					
PARENT OR GUARDIAN MUST SIGN FOR CHILD TO PARTICIPATE											
I am a custodial parent or legal guardian of the child named below. I give permission for my child to receive dental treatment, and allow the school nurse/school representative and dental provider access to my child's dental record. I also acknowledge that I have reviewed and received the Summary of Notice of Privacy Practices on the back of this form. I understand that I may ask for a copy of the full notice. To ensure program quality, my signature also gives permission for the Illinois Department of Public Health to review this record and to have WCHD return to school within 365 days from this date to check the retention of my child's sealants and replace if missing.											
Parent/Guardian Signature: _____							Date: _____				

This section needs filled out

SEE OTHER SIDE for INCOME GUIDELINES



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 2019-2020

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Child's Name:				Grade:		Teacher:		Birthdate: / /	
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County:		Phone:		Emergency Contact (Relationship):			Phone:		
Ethnicity:		Hispanic		Non-Hispanic		Race:		White	
								African American	
								Native American	
								Asian/Pacific Islander	
								Other: _____	
When was your child's last dental visit?				Dentist:		For what service?			
MEDICAL INFORMATION:									
Has child complained of dental problems?				YES		NO		If YES, what?	
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Has your child ever had any of the following? If YES, please circle:				Epilepsy		Currently has Heart Murmur		Latex Allergy	
								Diabetes	
								Asthma	
Seizures		Hepatitis		Anemia		Bleeding Disorders		Cancer	
								Thyroid Rheumatic Fever or Rheumatic Heart Disease	
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No Dental Insurance or ILLINOIS Medicaid / All Kids: (see chart on back for discounted fee eligibility)									
ILLINOIS Medicaid / All Kids: Provide Child ID #:									
Private Dental Insurance Company Name:									
Insurance Company's Address:					Insurance Co's Phone #:				
Insured's SSN or ID#:					Group #:				
Insured's Name:					Insured's Employer:				
Insured's Birthdate: / /			Address:			Phone:			
PARENT OR GUARDIAN MUST SIGN FOR CHILD TO PARTICIPATE									
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Parent/Guardian Signature: _____							Date: _____		

This section needs filled out

SEE OTHER SIDE for INCOME GUIDELINES

Using the Free and Reduced Lunch income guidelines below,
CIRCLE YOUR HOUSEHOLD SIZE AND MONTHLY GROSS INCOME RANGE:

If you do not have insurance **and** your student is in **2nd OR 6th** grade, based on your family size and income, you may be eligible for assistance from the Sealant Grant Program for your student's dental care.

PLEASE CIRCLE YOUR MONTHLY INCOME

If "**NOT ELIGIBLE**" for Free or Reduced Lunch, your child may be seen by the dentist for a **\$40.00** fee.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

You must circle the income section for a grant consideration.

Household Size	Free (130% FPL)	Reduced (185% FPL)	NOT ELIGIBLE
1	\$1,354 or under	\$1,355 – \$1,926	\$1,927 or greater
2	\$1,832 or under	\$1,833 – \$2,607	\$2,608 or greater
3	\$2,311 or under	\$2,312 – \$3,289	\$3,290 or greater
4	\$2,790 or under	\$2,791 – \$3,970	\$3,971 or greater
5	\$3,269 or under	\$3,270 – \$4,652	\$4,653 or greater
6	\$3,748 or under	\$3,749 – \$5,333	\$5,334 or greater
7	\$4,227 or under	\$4,228 – \$6,015	\$6,016 or greater
8	\$4,705 or under	\$4,706 – \$6,696	\$6,697 or greater
Each additional household member	Add \$479	Add \$682	Add \$682

**WHITESIDE COUNTY HEALTH DEPARTMENT & COMMUNITY HEALTH CLINIC
SUMMARY OF 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. *Please review it carefully.*

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims record
- Correct your health & claims record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you as your personal representative
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we may share your information:

- Disclosing information to your family and friends (requires written authorization)
- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information (requires written authorization)
- Raise funds

OUR USES AND DISCLOSURES

We may use & share your information as we:

- Treat you
- Run our organization
- Bill for your health services
- Help with public health and safety issues
- Do research
- Comply with the law, such as providing proof of immunity to a school
- Respond to organ & tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders such as voicemail messages, postcards, texts or letters

We will never share any health information regarding Behavioral or Mental Health Services, Substance Abuse (drug/alcohol) Treatment, Physical Assault/Abuse/Neglect, and/or Sexually Transmitted Diseases including HIV/AIDS.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.