

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.A. 161: PUBLIC DENTAL PREVENTION PROGRAM
Request for Operation as Defined in MCL. 333.16625 (2005 P.A. 161)

NEW PROGRAM

RENEWAL

Agency/Entity: _____

Program Name: _____

Address: _____

Non-profit ID Number _____ Entity Type 2 National
Provider Identifier (NPI) # _____

Executive Director/
Health Officer: _____

Contact Person: _____ Telephone Number: _____

E-mail address: _____

AGENCY/ENTITY DESIGNATION: (Choose one)

- | | |
|---|--|
| <input type="checkbox"/> Community Dental Clinic | <input type="checkbox"/> Prison System or Juvenile Detention Center |
| <input type="checkbox"/> FQHC (Federally Qualified Health Center) | <input type="checkbox"/> Public Health Agency |
| <input type="checkbox"/> Long-Term Care Facility / Nursing Home | <input type="checkbox"/> School of Dentistry or Dental Hygiene |
| <input type="checkbox"/> Non-Profit Agency | <input type="checkbox"/> School-Based or School-Linked Health Center |
| <input type="checkbox"/> Other: _____ | |

Describe the underserved population(s) to receive preventive services: (Check all that apply)

- Adult Foster Care Residents
- Early Head Start, Head Start Students or Other Underserved Preschoolers
- Inmates of Prison System
- Juvenile Home Residents
- Long-term Care Facility /Nursing Home Residents
- Migrant Farm Workers
- Native Americans
- Patients of a Public Health Agency/FQHC/Community Dental Clinic
- Persons with Developmental Disabilities
- School-based/school-linked program students with at least 25% of students participating in a free and reduced lunch program. Students treated must not have an assigned dentist.
- "Unassigned" persons who are dentally underserved
- Other: (explain) _____

Describe the clinical setting(s) in which the services are to be provided: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Adult Foster Care | <input type="checkbox"/> Mobile Dental Clinic |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Patient Home |
| <input type="checkbox"/> Faith Based Organizations | <input type="checkbox"/> Public Health Agency/FQHC/Community Dental Clinic |
| <input type="checkbox"/> Head Start/Preschool Centers | <input type="checkbox"/> School of Dentistry or Dental Hygiene Outreach Program |
| <input type="checkbox"/> Juvenile Home | <input type="checkbox"/> School-based/School-linked program |
| <input type="checkbox"/> Long-Term Care Facility/Nursing Home | <input type="checkbox"/> Tribal Health Centers |
| <input type="checkbox"/> Other: (Describe) _____ | |

Authority: MCL. 333.16625 (2005 P.A. 161)
Completion: Is voluntary, but is necessary to become a P.A. 161 Public
Dental Prevention Program.

Michigan Department of Community Health is an equal opportunity employer,
services and programs provider

Services Provided: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Fluoride Varnish | <input type="checkbox"/> Oral Health Education |
| <input type="checkbox"/> Pit and Fissure Sealants | <input type="checkbox"/> Topical Fluoride |
| <input type="checkbox"/> Prophylaxis | <input type="checkbox"/> Screenings |
| <input type="checkbox"/> Other Services: _____ | |

Data Report Form:

The Data Report Form must be submitted to the MDCH Oral Health Program quarterly on the 1st day of the month of January, April, July, and October. **This box must be checked by the administrator of this program**

- I have reviewed the required Data Report Form and will submit the required form on the date specified. Incomplete forms or forms not submitted when due will be cause to revoke or not renew the P.A. 161 status.

Supervising Dentist(s) and Registered Dental Hygienist(s)

All supervising dentists and dental hygienists must hold current State of Michigan licenses: *(Add additional pages as needed.)*

Supervising Dentist: _____	MI License # _____
Supervising Dentist: _____	MI License # _____
RDH Name: _____	MI License # _____
RDH Name: _____	MI License # _____
RDH Name: _____	MI License # _____
RDH Name: _____	MI License # _____

You are required to notify the MDCH Oral Health Program of any changes in staff, supervision, or services listed on the original application within 30 days. The supervising dentist must formally sign the change notification form stating that he/she agrees to supervise additional staff or state any changes to the original application. An original signature must be submitted, no faxes or e-mails. Names and license numbers are required for additional staff.

Supervision Circumstance:

The supervision of the registered dental hygienist must satisfy one or more of the following. Check the applicable supervision circumstance(s) provided by the dentist and registered dental hygienist(s) listed above:

- Continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed dentist.
- The availability of a licensed dentist on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual in the performance of the individual's functions.
- The provision by the licensed supervising health professional of predetermined procedures and drug protocol.

Required Supplemental Documents:

All of the following must be submitted with the P.A. 161 application.

- Supervision Protocol
- Parent/Guardian Permission Slip (if applicable)
- HIPAA Privacy Notice
- Patient Registration/Application Form
- Health History Review Form
- Infection Control Procedures

- If sealants are performed, provide the evaluation measures that will be taken to ensure long-term retention of the sealants.

- Patient Referral Protocol. Documentation must indicate how the patient will be referred for emergency dental services, how the patient will be counseled to seek an annual examination by a licensed dentist and describe the follow-up mechanism that is in place to determine if the patient has received dental services following referral.

- Evidence of non profit status if not associated with health dept, FQHC, or community clinic.

- Protocol for Child/Elder Abuse Reporting.

- Dental Hygienist Supervision Acknowledgement pages (one per dental hygienist under signature of Supervising Dentist)
- Support and/or agreement letters from dentists or oral health agencies that will accept your referrals if not associated with health dept, FQHC, or community clinic are strongly recommended.

Required Signatures - All information included in this P.A. 161 Public Dental Prevention Program Application Form is true and complete.

_____ Executive Director/Health Officer Signature	_____ Printed Name	_____ Date
_____ Dental Hygienist Signature	_____ Printed Name	_____ Date
_____ Dental Hygienist Signature	_____ Printed Name	_____ Date
_____ Dental Hygienist Signature	_____ Printed Name	_____ Date
_____ Dental Hygienist Signature	_____ Printed Name	_____ Date
_____ Supervising Dentist Signature	_____ Printed Name	_____ Date
_____ Supervising Dentist Signature	_____ Printed Name	_____ Date

Add an additional page with supervising dentist and dental hygienist signatures, if necessary. All signatures must be original (not photocopied). Faxed copies are not allowed.

SEND COMPLETED P.A. 161 PUBLIC DENTAL PREVENTION PROGRAM APPLICATION AND ALL REQUIRED DOCUMENTS TO:

Michigan Department of Community Health, Oral Health Program
P.O. Box 30195
Lansing, MI 48909

For more information contact the MDCH Oral Health Program, 517-335-8523, FAX: 517-335-8697, or oralhealth@michigan.gov subject line: P.A. 161

FOR MDCH OFFICIAL USE ONLY

Agency/Entity Name: _____

MDCH Oral Health Director recommends approval Date: _____

MDCH Oral Health Director does not recommend approval Date: _____

Rationale: _____

Christine Farrell, RDH, BSDH, MPA
Oral Health Director, MDCH

Date

Dental Hygienist Supervision Acknowledgement

(one per Dental Hygienist under signature of Supervising Dentist)

Note: Please read and discuss the following statements with each P.A. 161 dental hygienist you supervise for this program. Each supervising dentist needs to sign this page for each dental hygienist being supervised.

- We have reviewed the Data Reporting Form and agree to submission of the form as indicated.
- If special populations are the focus of care, P.A. 161 providers are encouraged to have current continuing education regarding the provision of dental care for these populations (i.e. geriatrics and special needs populations for long-term care facilities; behavioral management and sealant placement courses for school settings, etc.).
- A dental hygienist can only administer anesthesia and nitrous oxide analgesia or perform soft tissue curettage under the direct supervision of a dentist.
- P.A. 161 Program will be monitored for quality assurance and compliance. The MDCH Oral Health Program may conduct record audits, perform site visits, request other quality assurance data such as sealant retention data and patient referral documentation, and notify the Michigan Board of Dentistry of the findings.
- The MDCH Oral Health Program must be notified of any information changes within 30 days of the change. Changes to services, supervising dentists and practicing dental hygienists needs to be submitted on the change notification form.
- P.A. 161 Program must be renewed every two years. While the MDCH Oral Health Program will attempt to notify each P.A. 161 Program at least 1 month prior to expiration, renewal notification is not guaranteed.
- If a patient resides in a long-term care facility, a physician's order for dental services is required for Medicaid beneficiaries. The order cannot be a standing order.
- Proof of liability insurance is recommended for each provider.
- The supervising dentist should reside in the same geographic service area 10 out of 12 months where P.A. 161 services are provided and have an active or volunteer license in the state of Michigan.
- The supervising dentist may not supervise more than 25 hygienists at any one time.

As supervising dentist for this P.A. 161 Program I certify that I have read and reviewed with the following dental hygienist the above protocols in relation to our P.A. 161 Program:

P.A. 161 Program Name: _____

Dental Hygienist: _____

Supervising Dentist: _____

Signature of Supervising Dentist: _____

Date: _____

Signature of Registered Dental
Hygienist: _____

Date: _____