

**DENTAL SEALANT GRANT PROGRAM  
GRANT APPLICATION**

**(Fiscal Year 2011 — July 1, 2010 through June 30, 2011)**

In order to streamline the grant application process, the Division of Oral Health has developed several tools to assist with grant submission as well as program planning. The grant application guidance, targeting and budgeting forms are enclosed. Please complete a timeline and the required forms. Submit a narrative only if your program experienced a significant success or barrier OR if you plan a significant change to your program process, including new startup expansion and SEALs software use (see administrative funding criteria). An electronic copy of the grant application forms can be obtained by emailing <[Stacey.Ballweg@illinois.gov](mailto:Stacey.Ballweg@illinois.gov)>. Send **the original and two copies by the close of business on June 10, 2010** to the Illinois Department of Public Health, Office of Health Promotion, Division of Oral Health, 535 West Jefferson, Springfield, Illinois 62761 or by e-mail to <[Stacey.Ballweg@illinois.gov](mailto:Stacey.Ballweg@illinois.gov)>. Late grant applications will not be reviewed.

The enclosed Grant Award Request Form, timeline, Targeting Form A, Targeting Form B, all proposed agreements, subcontracts, and letters of support are all required. Thank you.

A completed application contains –

- Grant Award Request Form**
- Timeline**
- Targeting Forms A & B**
- School Eligibility Form**
- Attachments (proposed agreements, subcontracts, letters of support)**
  
- Narrative, if appropriate
- Budget Forms – (for Administrative Funding)
- Cavity Busters Curriculum Evaluation, if appropriate

Page

Dental Sealant Grant Program Grant Application Guidance ..... 2

**ATTACHMENTS:**

Grant Award Request Form (Attachment A) .....	7
Targeting Form A (Attachment B) .....	10
Targeting Form B (Attachment C) .....	12
Targeting Form C (Attachment D) .....	13
Billing Form Cover Sheet / Monthly Program Report Form (Attachment E) .....	14
Individual Exam Form (Attachment F) .....	15
Retention Rate Protocol (Attachment G).....	16
Retention Rate Reporting Form (Attachment H) .....	17
Retention Rate Collection Form (Attachment I).....	18
Grantee Workshop Save-the-Date (Attachment J).....	19
School Eligibility Form (Attachment K) .....	20
Cavity Busters Curriculum Evaluation (Attachment L).....	21
Budget Forms - <i>For those meeting criteria for administrative funding</i> (Attachment M).....	22

**DENTAL SEALANT GRANT PROGRAM**  
**Grant Application Guidance**

**(Fiscal Year 2011 — July 1, 2010 through June 30, 2011)**

**A. Program Description**

The purpose of the Dental Sealant Grant Program is to assist providers of public health services to develop and implement appropriate and feasible programs with clear and measurable objectives to provide dental sealants to Illinois children at high risk for dental caries. The Division of Oral Health will provide training and technical assistance for your agency. The FY2011 Grantee Workshop will be in Springfield on August 12, 2010 (see Attachment J). The workshop agenda includes vital program information and all grantees should attend.

Program Goal: To increase the proportion of children who have received protective sealants on their molar teeth.

Target: 50 percent, Healthy People 2010 Oral Health Objective 21-8  
Baseline: 27% (Division of Oral Health, 2004)

With a preference to local health departments as service providers, the Dental Sealant Grant Program will provide grantees reimbursement for the application of dental sealants to selected permanent molars for a targeted number of eligible children in a jurisdiction, and assisting families by assuring access to oral health education, fluoride varnish, All Kids enrollment, referral to a dental home, and mandatory school dental examinations for children in kindergarten, second and sixth grades.

For program development reference –

- ◆ Seal America: The Prevention Invention, 2<sup>nd</sup> Edition; [www.mchoralhealth.org/SEAL/](http://www.mchoralhealth.org/SEAL/)
- ◆ IDPH Fact Sheet; <http://www.idph.state.il.us/HealthWellness/oralhlth/oralsealants.htm>
- ◆ IDPH Providing Dental Sealants in Schools... Easier than you may think!;  
<http://www.idph.state.il.us/HealthWellness/oralhlth/Sealant%20Marketing%20-%20Providing%20Dental%20Services%20in%20Schools%20final.pdf>

**Eligible children are those school aged who are eligible to participate in the free or reduced school meals program.** Based on tooth eruption, first permanent molars erupt at age 6 and second permanent molars at age 12. The first and second permanent molars are most likely to develop cavities on the chewing surfaces in their deep pits and grooves. Targeting children in the second and sixth grades is most effective and efficient. Providing sealants for children is usually best in school settings. Targeting schools with the highest rate of low income children is best if all schools cannot be served.

The enclosed targeting forms (Attachments B, C, & D) will assist you to determine the amount of grant funding needed to provide care to the children in your community. Grantees may choose to use the services of a subcontractor to provide care. The Dental Sealant Grant Program may

provide grantees a one-time award (not to exceed \$7,500.00) for assisting in the purchase of portable dental equipment for the program. The grantee must demonstrate that they do not possess such equipment and that they do not have access to obtain such equipment on loan in their area. The grantee will assure that such equipment will be purchased at the least expensive cost as established by the Division of Oral Health. In the event that the grantee discontinues the program at any time, possession of the equipment will revert to the Illinois Department of Public Health.

In 2006, the Illinois School Code was revised by the 93<sup>rd</sup> Illinois General Assembly. The revisions require every schoolchild in kindergarten, second and sixth grades receive a dental examination prior to May 15<sup>th</sup> of the school year. This dental examination mandate gives a great opportunity to assist schoolchildren, their families, and the schools to complete this requirement. Grantees should work with schools to meet the needs of the low-income children who may not have access to the dental examinations outside your oral health program. The Division of Oral Health staff is available to work with you to assure exams, preventive services, and referral to dental homes.

In March 2008, the Journal of the American Dental Association published articles reporting recommendations regarding dental sealants. The findings, although specific for private dental providers, affirm our program philosophy and can be a useful tool in marketing our programs.

-AND-

In November of 2009, the Journal of the American Dental Association published an article reporting recommendations and reviews of evidence of caries prevention through school-based dental sealant programs. The findings are based on a Centers for Disease Control and Prevention expert workgroup that affirm this program philosophy and are a useful tool in marketing and program development (<http://jada.ada.org>).

## **B. Program Requirements**

- \* Demonstrate accessibility of the program to the target population. (Targeting forms are enclosed.)
- \* Agreements must be in place among participating parties (e.g. school administration for school-based program), sub-contracts, memoranda of agreement, letters of support from appropriate community agencies, schools and other organizations, and parent permission slips and referral forms. Schools must allow providers and IDPH quality assurance access to children for long-term retention checks.
- \* A written protocol outlining the specific process for referral to the oral health care delivery system of children found to need treatment services.
- \* A written protocol outlining All Kids outreach and enrollment.
- \* A written protocol outlining oral health education for children, preferably classroom education prior to dental sealant program participation. The Division of Oral Health has developed an oral health education toolbox for your use. Each new grantee will receive an education toolbox in order to provide uniform oral health education to classroom children. More information will be provided at the grantee workshop(s).
- \* A written protocol demonstrating evidence of Medicaid/All Kids denial and procedures for billing Medicaid/All Kids patients.
- \* A written protocol for quality assurance including:
  - \* technical acceptability of sealant application procedure including use of blunt ended explorers during examinations if explorers are used (use of sharp explorers

- is not recommended in detection of occlusal decay) and use of only white sealant application materials approved by the American Dental Association, and;
- \* long-term sealant retention rate collection (Retention Rate Forms and protocol are enclosed – Attachments G, H, & I). Assure retention rates of 90 percent or higher and provision of technical assistance for any provider falling below 90 percent. Permission slips must reflect provision for long-term retention checks by providers and IDPH QA audits.
  - \* Document conformity of proposed activities to professional standards, the Illinois Dental Practice Act and Rules Administering the Illinois Dental Practice Act <http://www.dpr.state.il.us>, Centers for Disease Control and Prevention on infection control and hand washing <http://www.phppo.cdc.gov/cdc recommends> and [www.cdc.gov/handhygiene/](http://www.cdc.gov/handhygiene/) and Healthcare and Family Services school-based provider mandates.
  - \* Guarantee provision of **dental sealants** for all appropriate children.
  - \* Assure experienced and competent staff to accomplish the program.
  - \* Comply with Illinois Department of Healthcare and Family Services school-based oral health program requirements.
  - \* Attendance at educational meetings and networking sessions as requested by the Division.
  - \* Comply with fiscal and program reporting requirements of the Illinois Department of Public Health.

The Division of Oral Health will entertain applications requesting administrative funds. This component of the Dental Sealant Grant Program application will be competitive. The Division of Oral Health will award administrative funds to applicants based on the following criteria —

- Program Development – Funding to assist new grantees in communities not currently covered.
- Program Expansion – Funding to assist existing grantees to expand into new areas.
- Program Evaluation – Funding to assist with implementation of the SEALs data collection system.

The Division of Oral Health will determine the grantees that qualify and their administrative award amount based on need and ability to build sustainable community-based oral health programs employing staff with oral health expertise and linking families to dental homes.

If the applicant wishes to apply for this portion of the grant, they must include a brief explanation of their request and a budget. The budget must address the administrative funding and include the patient care dollars requested. Budget forms are attached (Attachment M).

### C. Payment Methodology

The method of compensation for the Dental Sealant Grant Program is fee-for-service. **The Department will pay the grantee at the rate equal to the 2005 Medicaid rate** for school-based services per permanent molar sealed and examination per child receiving dental sealants and all participating children in the second and sixth grades not enrolled in Medicaid/All Kids. **The grant does not pay for dental exams on children who do not receive sealants except for children in the second and sixth grades.**

Administrative funding will be reimbursed through submission of Certificate of Reimbursement forms.

In addition, a one-time reimbursement for purchase of equipment (not to exceed \$7,500.00) may be authorized in the initial grant period. In the event that the grantee discontinues the program at any time, possession of the equipment will revert to the Illinois Department of Public Health.

A monthly program report (Attachment E), including fees to be reimbursed, must be provided to the Department by the grantee no later than 30 days after the end of the month using a reporting form supplied by the Division of Oral Health. **Electronic copies of the billing forms may be obtained by contacting Stacey Ballweg at 217.785.1072 or <[Stacey.Ballweg@illinois.gov](mailto:Stacey.Ballweg@illinois.gov)>.**

The final reimbursement request shall be received by the Department by July 31, 2011.

**D. Source of funds**

Maternal and Child Health Services Block Grant

**E. Contact**

For additional information, please contact Ms. Julie Ann Janssen at 217.785.4899 or e-mail at <[Julie.Janssen@illinois.gov](mailto:Julie.Janssen@illinois.gov)>.

**F. Application**

Required documents for the Division of Oral Health, Dental Sealant Grant Program Application include:

- Grant Award Request Form (Attachment A) – narrative (if appropriate) and timeline for FY11
- Targeting Forms – A & B (Attachments B & C)
- List of subcontractors is required on the Grant Award Request Form and a copy of the contract with the subcontractor (or a draft of the contract until a contract is finalized)
- Copies of agreements with schools
- Letters of support

For continuation applications, the narrative should address any significant changes or accomplishments during FY10, and may include charts, graphs, or tables.

Proposed revisions to the project shall be submitted as part of the narrative to justify a significant change in requested funding.

For those grantees using SEALS, please include a brief evaluation of your implementation (what worked, what did not).

**G. Evaluation/Funding Criteria**

Applications will be reviewed, evaluated, and funded based on program need as demonstrated on targeting forms, availability of funds and, if appropriate, histories of efficient use of dental sealant grant funds.

Illinois is one of the premier dental sealant programs in the United States. We are doing a great job. Thank you for all you do for Illinois' children's oral health.

**Please submit electronic grant application to <[Stacey.Ballweg@illinois.gov](mailto:Stacey.Ballweg@illinois.gov)> or original and two copies of the application by June 10, 2010 to:**

**Illinois Department of Public Health  
Division of Oral Health  
535 West Jefferson Street  
Springfield, IL 62761**

DENTAL SEALANT GRANT PROGRAM
GRANT AWARD REQUEST
(Fiscal Year 2011 — July 1, 2010 through June 30, 2011)

Agency \_\_\_\_\_

County(ies) Served \_\_\_\_\_

Address \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail \_\_\_\_\_

Table with 4 columns: Item, Amount, Administrative Award Request, Amount. Rows include Patient Care, Equipment (new grantees - \$7,500), and Award Request.

List Subcontractor(s) \_\_\_\_\_

Include copy of contract(s). A draft copy is adequate until a contract is finalized.

Dentists Medicaid Provider Number (s) 0190-\_\_\_\_ 0190-\_\_\_\_

Include all providers that are submitting bills to Medicaid in conjunction with the Program.

Location ID Number (s) # \_\_\_\_\_

Include all location ID numbers that are used in conjunction with the Program.

Table with 4 columns: Protocols in Place, Protocol Name, Yes, No. Rows include Patient Referral, All Kids Outreach, Medicaid/All Kids Billing, Quality Assurance, Retention Rates, Sealant Application Procedure, Oral Health Education.

Retention Rates: FY09 - Average Long-Term Retention Rate \_\_\_\_\_%

- 1. Does your oral health program have a designated and unique budget? (A line-item in agency's budget designated for dental) [Yes] [No]

(Continued on next page)

**DENTAL SEALANT GRANT PROGRAM  
GRANT AWARD REQUEST  
(Continued)**

2. Do you use general supervision of dental hygienists in your program? Yes No  
If yes, please indicate under what circumstances general supervision is used.
3. Do you target children in second and sixth grades? Yes No  
Do you serve children in all grades? Yes No  
Do you provide school examinations for children in Kindergarten? Yes No  
Please briefly explain grade selection.
4. Do you provide topical fluoride applications? Yes No  
Do you use fluoride varnish? Yes No
5. Do you use volunteer dentists and/or dental hygienists? Yes No  
If yes, please briefly describe.
6. Do you provide sealants in a school-based setting? Yes No  
Do you provide sealants in a dental clinic or office? Yes No  
If yes, is your program linked to a school? Yes No  
Do you use both school and clinic/office-based settings? Yes No  
Please briefly describe.
7. Do you collect oral health data from the program? Yes No  
Is the data entered into a computerized data system? Yes No  
If yes, which software do you use?
8. Do you have a dental sealant program coordinator? Yes No  
Please briefly describe. (Oral Health Professional? FTE?)

**(Continued on next page)**

9. Do you have a case management system to assure referral? Yes No  
If yes, please briefly describe.

10. Do you use the Cavity Busters dental curriculum? Yes No  
Do you provide the Cavity Busters curriculum to your schools? Yes No  
If yes, please complete the survey (Attachment L)

11a. What is your program's jurisdiction (i.e., city, township, county, multiple county, school district, etc.)?

11b. List all by name:

12. Please include, on a separate sheet, a list of all schools that you served in FY10.

Timeline:

Provide a timeline indicating when the program will be in schools in FY11.

Narrative:

Address any significant success, challenges, or changes only.

**TARGETING FORM A — REQUIRED**  
**Dental Sealant Grant Program (DSGP)**

Target Schools

	<b>REQUIRED</b>			Complete for Schools/School Programs serving K & Pre-K		
	1	2	3	4	5	6
List Schools	Total # of students in targeted grades	<b>Targeted Children</b> Total # of students participating in free and reduced meals <i>(including All Kids / Medicaid)</i> <b>(Estimated)</b>	Total # of students enrolled in All Kids / Medicaid <b>(Estimated)</b>	Total # of K & Pre-K students	Total # of K & Pre-K students participating in free and reduced meals <b>(Estimated)</b>	Total # of targeted students in K & Pre-K enrolled in All Kids / Medicaid <b>(Estimated)</b>
<b>TOTALS</b>						

Column 2 minus Column 3 = Total targeted grant children ⇒

**For Targeting Form B**

For list of schools: <http://www.isbe.state.il.us/research/htmls/directories.htm>

**TARGETING FORM A — REQUIRED**  
**Dental Sealant Grant Program (DSGP)**

Fill out this form for all schools in your community that you are planning to target for the sealant program.

Schools should be given preference where more than 50% of the children are enrolled in the free/reduced lunch program.

This form can be used to determine which schools in the community will benefit most from participating in the program.

**You may choose to serve a selected number of schools targeting all eligible children in the school, then rotate schools each year.**

Schools should be able to tell you an estimated number of children enrolled in the free and reduced meals program.

**TARGETING FORM B — REQUIRED**  
**Dental Sealant Grant Program (DSGP)**

Prepare one Targeting Form A and use total numbers from all participating schools to complete this form. **These rates are current as of March 2010 and are subject to change.** Assume Medicaid/All Kids wherever you see Medicaid on this form.

**Calculate Grant Funding Request:**

- # of Targeted Students \_\_\_\_\_ ⇒ From Targeting Form A.
- # of Targeted Grant Students \_\_\_\_\_ ⇒ From Targeting Form A.
- Permission Slip Return Rate \_\_\_\_\_ ⇒ Divide the number of permission slips returned by the number of permission slips distributed. Calculate permission slip return rate based on previous years' programs or your experience or the school(s) input. (First time grantees: estimate based on other school programs or use 50%.)
- # of Medicaid Students to be served \_\_\_\_\_ ⇒ Multiply the number of Medicaid students with the permission slip return rate.
- Estimated Total Medicaid Revenue \_\_\_\_\_ ⇒ Multiply the number of Medicaid students to be served by \$136.00.  
(exam (\$28.00) + sealants (3 @ \$36.00=\$108.00))  
Programs report the average number of sealants per child as **three**. You may use **four** if that is your program's average.
- Other Medicaid Revenue (Optional) \_\_\_\_\_ ⇒ Multiply the number of Medicaid students to be served by \$67.00.  
(prophy (\$41.00) + fluoride (\$26.00))  
Some DSGPs choose to provide the additional preventive services of prophylaxis and fluorides for the students on Medicaid.
- # of Grant Students to be served \_\_\_\_\_ ⇒ Multiply the number of Targeted Grant students with the permission slip return rate.
- Total DSGP Grant Funding Request \_\_\_\_\_ ⇒ Multiply the number of Grant students to be served by \$52.20.  
(exam (\$9.90) + sealants (3 @ \$14.10=\$42.30))

**The Total Medicaid/All Kids and Total Grant Revenues are estimates.** The Dental Sealant Grant Program reimburses for all exams on 2nd and 6th graders even if those children do not receive (need) dental sealants. For children in other grades, exams will be reimbursed only if sealants are placed.

**TARGETING FORM C — NOT REQUIRED – Use for Program Planning  
Dental Sealant Grant Program (DSGP)**

This information will assist you and your provider to determine the amount of time needed for your program. The number of DSGP children and the number of Medicaid/All Kids children to be served is found on Targeting Forms A and B. When calculating time needed for each student, take into account:

- \* If your program examines children in the dental chair then immediately provides dental sealants if needed.
- \* If your program examines all children first. Then you will need to add the number of days needed for those examinations to the # of days needed in school.

**Calculate Production Schedule\Time Needed:**

Time needed per student	_____ Hours	⇒	Every provider may differ in speed and skill of dental sealant application.
Time available each day	_____ Hours	⇒	This depends on issues such as transportation, school calendar and provider availability. A typical school day is 6.5 hours.
# of providers/equipment	_____	⇒	Ask your participating dentist or subcontractor for the number of providers/chairs they will fill at one time.
# of students each day	_____	⇒	Divide the available hours each day by the time needed for each student. Multiply this number by the number of providers/equipment.
# of days needed in school	_____	⇒	Divide the total number of students to be served (DSGP <i>and</i> Medicaid) by the number of students each day.

Illinois Department of Public Health  
 Office of Health Promotion/Division of Oral Health  
 535 West Jefferson Street  
 Springfield, Illinois 62761  
**DENTAL SEALANT GRANT PROGRAM**  
**MONTHLY PROGRAM REPORT SHEET**  
**Fiscal Year 2011**

**Attachment E**

Agency Name \_\_\_\_\_  
 \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_  
 \_\_\_\_\_  
 Contact Person \_\_\_\_\_

**FOR ALL  
 PROGRAMS**  
*(for an electronic version of this  
 form, please contact  
 <Stacey.Ballweg@illinois.gov>)*

Contract # \_\_\_\_\_

TIN # \_\_\_\_\_

Billing Month \_\_\_\_\_

Date Submitted \_\_\_\_\_

**SEALANTS** \_\_\_\_\_ @ \$36.00 = \$ \_\_\_\_\_  
 (Total # of permanent 1<sup>st</sup> & 2<sup>nd</sup> molars sealed) (Medicaid Rate)

**GRANT-ELIGIBLE EXAMS** \_\_\_\_\_ @ \$28.00 = + \$ \_\_\_\_\_  
*Individual Exam Form attached.* (Medicaid Rate)  
 (The number of exams performed on all second & sixth grade children in addition to the number of exams for children in other grades if the child received a sealant.)

TOTAL \$ \_\_\_\_\_

**OTHER EXAMS** \_\_\_\_\_ @ \$28.00 = \$ \_\_\_\_\_  
 (The number of exams performed on children that did not receive a sealant — excluding those children in second or sixth grade.) (Medicaid Rate)

**Summary of Children Served**

**TOTAL # OF CHILDREN SERVED** \_\_\_\_\_

**TOTAL # OF SEALANTS APPLIED** \_\_\_\_\_

# of DSGP children \_\_\_\_\_

# of DSGP sealants \_\_\_\_\_

# of Medicaid/All Kids children \_\_\_\_\_

# of Medicaid/All Kids sealant \_\_\_\_\_

# of other children (other funding) \_\_\_\_\_

# of other sealants (other funding) \_\_\_\_\_

**Signature** \_\_\_\_\_

**Authorized Agency Official**

(Submit one original of the Monthly Program Report Sheet  
 and one copy of the individual exam forms for grant-eligible exams and sealants.)

(Rev. 04/07/2010)

DSGP Child

Medicaid/ASSISTED CHILD

Dental Sealant Grant Program Individual Exam Form  
Illinois Department of Public Health

**Attachment F**

Agency Name \_\_\_\_\_

Child's Name \_\_\_\_\_  
(Last) (First)

Child's Address \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race:  White  Black  Asian/Pacific Islander  AMERICAN INDIAN/ALASKAN NATIVE

School Name \_\_\_\_\_ Grade:  2  6  Other \_\_\_\_\_

School Code \_\_\_\_\_  
Region County District School Type

Sealants Present:  Yes  No *(Prior to exam — 1<sup>st</sup> permanent molars only)*

Caries Experience:  Yes  No *(A filling (temporary/permanent), OR a tooth that is missing because it was extracted as a result of caries.)*

Cavitated Lesion:  Yes  No *(At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.)*

Urgent Treatment:  Yes  No *(Abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.)*

**Initial Exam Record**

(Tooth #/Letter – D,M,F — specify tooth surfaces affected and type of restoration present)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment Record**

Service	Date	Tooth #							
		2	3	14	15	18	19	30	31
Exam									
Seal									
Retention									
Reseal									
Referral									

Total # of permanent molar sealants \_\_\_\_\_

Exam (child either received a sealant or is in second or sixth grade)  Yes  No

Dentist Signature \_\_\_\_\_

(Rev. 04/04/2008)

**FOR PROGRAMS NOT USING SEALS**  
*(for an electronic version of this form, please contact <Stacey.Ballweg@illinois.gov>)*

## Retention Checks

Retention checks are an excellent way to measure effectiveness of the dental sealant program. The primary reason that a dental sealant is retained is proper application. **The Division of Oral Health requires that retention rates be 90 percent or higher.** If the rate falls below 90 percent, then the grantee must seek technical assistance and re-mediation and report resolution to the Division of Oral Health. The most common areas of concern are: defective sealant material, water in the air lines, poorly timed etching and rinsing, or problems keeping a dry field of operation.

The Division of Oral Health asks each Dental Sealant Grant Program to long-term retention rates annually. Long-term rates reflect retention for one year or more from application.

## Retention Protocol

1. Check long term retention rates the following year.
2. Check retention rates on a 20 percent sample of students from each provider.
3. The sample of students should be selected as follows:
  - \* List all students that received sealants.  
(Existing list, classroom list, or clinic list).
  - \* Select every 5th student starting with the first student – number 1.  
i.e., 1st, 6th, 11th, 16th, etc.
  - \* Complete the Retention Rate Form to obtain retention rate.
4. Use a code selected by your agency to list providers and students.

# DENTAL SEALANT GRANT PROGRAM

Attachment H

## Long-Term Retention Rates - Required for Division of Oral Health

Agency \_\_\_\_\_

School Year \_\_\_\_\_

1	2	3	4	5	6
Provider Identifier	Total # of Teeth Sealed	Total # of Teeth Needing Add-on Sealant	Total # of Teeth Needing Total Re-Seal	Total # of Teeth with Retained Sealant <i>(Column 2 minus Columns 3 &amp; 4)</i>	Retention Rate <i>(Column 5 divided by Column 2 X 100)</i>
					%
					%
					%
					%
					%
					%
					%
					%
Column 6 Total					%
<b>Overall Program Retention Rate - Column 6 total divided by # of entries in column 6 =</b>					<b>%</b>

## DENTAL SEALANT GRANT PROGRAM

**Long-Term Retention Rates - For Grantee Use - Do not submit to the Division of Oral Health**

**Provider/Operator** \_\_\_\_\_

**School** \_\_\_\_\_

1	2	3	4	5
Student Identifier	Total # of Teeth Sealed	Total # of Teeth Needing Add-on Sealant	Total # of Teeth Needing Total Re-Seal	Total # of Teeth with Retained Sealant <i>(Column 2 minus Columns 3 &amp; 4)</i>
<b>TOTALS</b>				
<b>Retention Rate - Divide total of Column 5 by total of Column 2 then multiply by 100 =</b>				



# Save the Date

## FY2011 Grantee Workshop

Thursday, August 12, 2010

10:00 am - 3:00 pm

Springfield, Illinois  
Crowne Plaza

**Please plan on attending this meeting!**

\_\_\_\_\_ Number of schools Eligible (All in your jurisdiction: public, private, special, grade center, elementary, middle, intermediate, junior high school, high school) – FY11

\_\_\_\_\_ Number of schools Selected (Your criteria) – FY11

1. Check each that factor into your selection criteria; 2. Circle the priority level where appropriate; 3. Note why not, if not checked.

___ % of High Risk (% on FRM)	HIGH MEDIUM LOW _____
___ Proximity to: LHD, dental clinic, _____	HIGH MEDIUM LOW _____
___ Within a political jurisdiction	HIGH MEDIUM LOW _____
___ Amenable Administration	HIGH MEDIUM LOW _____
___ Within the 365 + 1 day requirement _____	

\_\_\_ Private \_\_\_\_\_

\_\_\_ Public \_\_\_\_\_

by grades/ages

\_\_\_ Pre-K \_\_\_\_\_

\_\_\_ Elementary \_\_\_\_\_

\_\_\_ Middle \_\_\_\_\_

\_\_\_ Intermediate \_\_\_\_\_

\_\_\_ Junior High School \_\_\_\_\_

\_\_\_ High School \_\_\_\_\_

\_\_\_ Special Education \_\_\_\_\_

\_\_\_ Grade Center \_\_\_\_\_

Comments/Other:

\_\_\_\_\_ Number of Schools Selected in FY10

\_\_\_\_\_ Number of Schools Served in FY10

If this number is different than those "Selected", or if there were changes to which schools actually participated: 1. Check all that apply, 2. Briefly explain why.

\_\_\_ Time/Schedule \_\_\_\_\_

\_\_\_ Staff – quit, hired, not able to treat special needs \_\_\_\_\_

\_\_\_ # of permissions \_\_\_\_\_

\_\_\_ Transportation \_\_\_\_\_

\_\_\_ School would not let you in – testing, no extras, went with a competing program \_\_\_\_\_

\_\_\_ Medicaid Reimbursement (365 + 1 day) \_\_\_\_\_

Comments/Other:

# CAVITY BUSTERS CURRICULUM EVALUATION

**Look Mom. . . . No Cavities!!**

(Evaluation Form 2008)

Grantee \_\_\_\_\_

	Yes	No	Grade level (s) used in (K, 1,2,3,4,5,6,7 & Higher)	Number of children participated
<b>Did you use the Cavity Prevention Topic?</b>				
Will you be using this topic in the future?				
<b>Did you use the Tooth Decay Topic?</b>				
Will you be using this topic in the future?				
<b>Did you use the Teeth &amp; Bacteria Topic?</b>				
Will you be using this topic in the future?				
<b>Did you use the Oral Health Habits Topic?</b>				
Will you be using this topic in the future?				
<b>Did you use the Nutrition Topic?</b>				
Will you be using this topic in the future?				
<b>Did you use the Career Development Topic?</b>				
Will you be using this topic in the future?				
<b>Did you use the Other Topic?</b>				
Will you be using this topic in the future?				
<b>Which topic did you like best?</b>				
<b>Which topic did you like least?</b>				

**Do you have suggestions for improvements? If so, please share on the back of this sheet.**

(04/07/2008)

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## Budget and Justification

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### Use of Funds

All grant funds must be used for the sole purposes set forth in the grant proposal and application and must be used in compliance with all applicable laws. Grant funds may not be used as matching funds for any other grant program. Use of grant funds for prohibited purposes may result in loss or recovery of grant funds. To be reimbursable under an IDPH/Office of Health Promotion Grant Agreement, expenditures must meet the following under general criteria:

- Be necessary and reasonable for proper and efficient administration of the program and not be a general expense required to carry out the overall responsibilities of the local health department.
- Be authorized or not prohibited under federal, state or local laws or regulations.
- Conform to any limitations or exclusions set forth in the applicable rules, program description or grant agreement.
- Be accorded consistent treatment through application of generally accepted accounting principles appropriate to the circumstances.
- Not be allocable to or included as a cost of any state or federally financed program in either the current or a prior period.
- Be net of all applicable credits.
- Be specifically identified with the provision of a direct service or program activity.
- Be an actual expenditure of funds in support of program activities, documented by check number and/or internal ledger transfer of funds.

Examples of allowable costs include the following: This is not meant to be a complete list, but rather specific examples of items within each line item category.

#### Personal Services:

- Gross salary paid to agency employees directly involved in the provision of program services.
- Employer's portion of fringe benefits actually paid on behalf of direct services employees; examples include FICA (social security), life/health insurance, Workers Compensation insurance, Unemployment insurance and pension/retirement benefits.

#### Contractual Services

- Conference registration fees
- Contractual employees (requires prior program approval)
- Postage, postal services, UPS or other carrier costs
- Software for support of program objectives
- Subscriptions
- Training and education costs

Note: Payments (or pass-through) to subcontractors or subgrantees are to be shown in the Contractual Services section - all subcontracts or subgrants require an attached detail line item budget supporting the contractual amount.

#### Travel

- Mileage (at \$0.505, state rate unless specifically noted otherwise)
- Airline (coach) or rail transportation expenses
- Lodging
- Per diem and meal costs

Commodities (Supplies)

- Office supplies
- Medical supplies
- Educational and instructional materials and supplies, including booklets and reprinted pamphlets
- Equipment items costing less than \$100 each

Printing (included in Supplies)

- Letterpress, offset printing, binding, lithographing services
- Photocopy paper, other paper supplies
- Envelops, letterhead, etc.

Equipment (requires prior written approval)

- Items costing over \$100 with useful life of more than one year. Equipment costs shall be limited to 5 percent or less of the total grant award. Equipment costs shall include all freight and installation charges
- Office equipment and furniture
- Allowable medical equipment
- Reference and training materials and exhibits
- Book and films

Telecommunications (included in Contractual Services)

- Telephone services
- Answering services
- Installation, repair, parts and maintenance of telephones and other communication equipment

**Unallowable or prohibited uses of grant funds include, but are not limited, to the following:**

- Indirect or Administrative Cost Plan Allocations - Normal daily operating expenses may not be billed in any grant issued by the Office of Health Promotion
- Political or religious purposes
- Contributions or donations
- Incentives (This does not include those items that are used to generate visibility for program efforts, increase public awareness, or those that are used to reinforce a positive behavior change)
- Fund raising or legislative lobbying expenses
- Payment of board or non-program related debts, fines, or penalties
- Contribution to a contingency fund or provision for unforeseen events
- Entertainment, food, alcoholic beverages and gratuities
- Membership fees (unless related to program and approved in advance by IDPH)
- Interest or financial payments or other fines or penalties
- Purchase or improvement of land or purchase, improvement or construction of a building
- Equipment in excess of 5 percent of the grant award (unless approved by IDPH)
- Any expenditure that may create conflict of interest or the perception of impropriety

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH PROMOTION  
DETAILED RFA BUDGET**

**Grantee Name** \_\_\_\_\_

**Program** \_\_\_\_\_

		<b>TOTALS</b>
<b>A. Personnel Services</b>		\$ _____
	Detailed costs must be listed on Attachment I.	
<b>B. Fringe Benefits</b>		\$ _____
	Detailed percentages must be listed on Attachment I.	
<b>C. Contractual Services</b>		\$ _____
	Detailed list of services directly attributable to the program and potential contractors must be listed on Attachment II.	
<b>D. Supplies</b>		\$ _____
	Detailed list of supplies and vendors directly attributable to the program must be listed on Attachment III.	
<b>E. Travel</b>		\$ _____
	Detailed travel requests directly attributable to the program must be listed on Attachment IV.	
<b>F. Equipment</b>		\$ _____
	Potential purchases directly attributable to the program must be listed on Attachment V.	
<b>G. In-Kind Contribution</b>		\$ _____
	List value of non-IDPH requested funds/in-kind contributions that will be used to support project.	
<b>TOTAL DIRECT PROGRAM EXPENSES</b>		<b>\$ _____</b>

**Personnel Services**

<b>Name of Employee</b>	<b>Position Title (as applicable to program)</b>	<b>Monthly Salary</b>	<b>% of Time on Program</b>	<b>Amount Requested</b>
Other funds / In-Kind Contributions:				
<b>Fringe Benefits</b>				<b>Amount Requested</b>
Itemize Each Component & Percentage				

NOTE: Cost Allocation Plans are not allowed.

**Contractual Services**

<b>Name of Contractor / Service</b>	<b>Justification (as applicable to program)</b>	<b>Amount Requested</b>
Other funds / In-Kind Contributions:		

NOTE: Cost Allocation Plans are not allowed.

**Supplies**

<b>Name of Supplies / Vendor</b>	<b>Justification (as applicable to program)</b>	<b>Amount Requested</b>
Other funds / In-Kind Contributions:		

NOTE: Cost Allocation Plans are not allowed.

**Travel**

**(Must list all employees individually)**  
**(Costs for employees not listed on budget will not be reimbursable)**

<b>Name of Traveler / Employee</b>	<b>Justification (as applicable to program)</b>	<b>Amount Requested</b>
Other funds / In-Kind Contributions:		

NOTE: Cost Allocation Plans are not allowed.

**Equipment**

<b>Name of Equipment / Vendor</b>	<b>Justification (as applicable to program)</b>	<b>Amount Requested</b>
Other funds / In-Kind Contributions:		

NOTE: Cost Allocation Plans are not allowed.