

**DENTAL SEALANT ORAL HEALTH PROGRAM
GRANT APPLICATION**

(Fiscal Year 2012 — July 1, 2011 through June 30, 2012)

The Dental Sealant Grant Program assists providers of public health services to develop and implement appropriate and feasible programs with clear and measurable objectives to provide preventive oral health care to Illinois children at high risk for dental caries.

The grant application guidance and grant specific forms are enclosed.

A complete application will include the Illinois Department of Public Health Grant Application form and Budget forms found at <<http://www.idph.state.il.us/fundop.htm>> plus the Dental Sealant Grant Program (DSGP) specific forms included in this packet.

An electronic copy of the DSGP grant application forms can be obtained by emailing <Stacey.Ballweg@illinois.gov>. Send **one original by the close of business on June 15, 2011** to the Illinois Department of Public Health, Office of Health Promotion, Division of Oral Health, 535 West Jefferson, Springfield, Illinois 62761. **The grant applications must have an original signature, therefore, electronic submissions are not allowed.** 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 in addition to the Department's application and budget forms. A completed application contains –

- IDPH Grant Application**
- W-9 Form**
- IDPH Budget Forms**

For Section 7 – Grant Scope of Work - Attach and reference the following:

- Grant Award Request Form**
- Timeline**
- Targeting Forms A & B**
- School Eligibility Form**
- Attachments (proposed agreements, subcontracts)**

- Narrative, if appropriate - 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).

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DENTAL SEALANT GRANT PROGRAM
Grant Application Guidance

(Fiscal Year 2012 — July 1, 2011 through June 30, 2012)

A. Program Description – Appropriate for the Department’s Application under Section 5.

The **Dental Sealant Grant Program** (DSGP) assists Illinois schoolchildren who are most at risk for dental caries by granting funds and giving technical assistance and training to public health departments and others service providers to develop and implement community-based oral health programs. Dental sealants are a plastic coating applied to the pit and fissure surfaces of molars and premolars that "seal" out dental decay. When combined with appropriate diet, home care, and use of fluorides, dental sealants can virtually eradicate dental decay, the most common childhood chronic disease. This school-based/-linked program includes: preventive oral health care, oral health education and referral to dental homes. It has been the catalyst for expanding community-based oral health programs throughout the state. It is an essential component to a continuum of oral health care focusing on children and their families who are at the most risk for dental disease. The DSGP currently exists in 72 of the 102 counties in the state and serves approximately 170,000 children placing 300,000 dental sealants annually.

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

Objectives: To increase the proportion of Illinois children who receive oral health care.

To increase the proportion of children in Kindergarten, second and sixth grades receiving required school dental examinations.

To increase the number of communities in Illinois with public health oral health programs.

To increase the proportion of very young children that receive fluoride varnish applications.

To increase the proportion of eligible children that are benefitting from AllKids oral health benefits.

To increase the number of Illinois dentists that are participating as providers in the Department of Healthcare and Family Services dental program.

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, AllKids 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, 2nd Edition – 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. Placing dental sealants as soon as possible after the tooth erupts is best. 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 sub-contractor 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 93rd Illinois General Assembly. The revisions require every schoolchild in kindergarten, second and sixth grades receive a dental examination prior to May 15th of the school year. Grantees should work with schools to meet the needs of the low-income children who may not have access to the dental examinations outside of 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.
- * 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/cdcrecommends> and www.cdc.gov/handhygiene/ and Healthcare and Family Services school-based provider requirements.
- * 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, quality assurance, case management.
- Program Evaluation – Funding to assist with data collection system and implementation of the SEALs software.

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.

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>.**

The final reimbursement request shall be received by the Department by July 31, 2012.

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 FY12 depicting when the program is in the schools
- Targeting Forms – A & B (Attachments B & C)
- Subcontractor(s) information is required on the Public Health Grant Application. Also include a copy of the contract with the subcontractor (or a draft of the contract until a contract is finalized)
- Copies of agreements with schools and other partners

For continuation applications, the narrative should address any significant changes or accomplishments during FY11, 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.

The grant applications must have an original signature, therefore, electronic submissions are not allowed. **Please submit one original grant application by June 15, 2011 to –**

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

FOR IDPH Use Only

Application No. _____

Date Received _____



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR PUBLIC HEALTH GRANT
Office of Health Promotion
Division of Oral Health / Dental Sealant Grant Program

Section 1. APPLICANT INFORMATION

| | |
|---|--|
| Legal Name of Applicant: <i>(Attach copy of W-9)</i> | |
| Name and Title of Chief Officer: <i>(If more than one, attach a list of all officers)</i> | Name: Title: Address: Phone: Fax: E-mail: |
| Applicant Address: | |
| City, State, Zip Code: | |
| Telephone: | |
| Fax: | |
| E-Mail: | |
| Web Site: | |

Section 2. APPLICANT GRANT HISTORY

| | |
|---|---|
| Description of Applicant Organization: <i>(200 Character Maximum)</i> | |
| Has this Applicant received a grant from the federal government or the State of Illinois within the last 3 years? If yes, provide the following: <i>(Add additional rows if needed)</i> | <input type="checkbox"/> YES <input type="checkbox"/> NO Agency providing grant funding: Grant Number: Grant Amount: Grant Term: Brief Description of grant: |

| | |
|--|--|
| DUNS Number: | |
| Illinois Department of Human Rights Number (if applicable): | |
| Legislative Senate District: | |
| Legislative House District: | |
| Congressional District: | |

| Section 4. KEY GRANT CONTACT INFORMATION | |
|---|--|
| Grant Application Contact/Title: | |
| Telephone: | |
| Fax: | |
| E-Mail: | |
| Fiscal Contact/Title: | |
| Telephone: | |
| Fax: | |
| E-Mail: | |

| Section 5. GRANT PROJECT PROPOSAL | |
|--|--|
| Project Title: | |
| Brief Project Description: <i>(350 character maximum). Note that the Scope of Work must be completed separately.</i> | |
| Project Period: <i>(Include start and end date)</i> | |
| Total Amount of Funding Requested from IDPH: | |
| Total Applicant Match or In-Kind Contribution: | |

| | |
|--|--|
| If subcontractors will be used under this grant application, provide name, address and description of services. | Subcontractor name: Address: City, State, Zip: Phone: Description of services: |
| | Subcontractor name: Address: City, State, Zip: Phone: Description of services: |

| Section 6. GRANT BUDGET SUMMARY <i>(Note: This section is for summary purposes only. A detailed budget is/may be required. See Section 7)</i> | | |
|---|--|---|
| Budget Line Items Requested | Requested Grant Budget Amount | Applicant Match of In-Kind Contribution |
| Personal Services <i>(Includes Salary and Wages)</i> | | |
| Fringe Benefits (Percent use for calculation ____%) | | |
| Contractual Services (detailed information about the contractual services amount must be submitted on the attached budget excel form) | | |
| Travel | | |
| Commodities/Supplies | | |
| Printing | | |
| Equipment | | |
| Telecommunications | | |
| Patient/Client Care | | |
| Administrative Costs <i>(If applicable/allowable)</i> This line item can be removed by Program if not allowable | | |
| Grand Total | | |
| If the proposed budget includes Personal Services (Salary or Wage) related costs, please indicate the type of documentation that will be maintained and used to allocate staff costs to the grant. | <input type="checkbox"/> Time Sheets <input type="checkbox"/> Cost allocation plans <input type="checkbox"/> Certifications of time allocable to grant <input type="checkbox"/> Other, please describe _____ <input type="checkbox"/> Not applicable to this grant application | |

Section 7. GRANT SCOPE OF WORK

This section is to be developed by each program use to request information from the grantee that is specific to the grant being issued. Information/data collected **must** include, but not be limited to:

- Detailed description/information about the proposed project
- Expected outcomes
- Description of how outcomes will be measured
- List of goals to be accomplished during the grant period
- Proposed timeline
- Objectives by quarter with a list of tasks that will be implemented to accomplish the objectives. The organization shall specify how the objectives will be measured to determine successful completion.
- Detailed budget by line item and justification. The attached detailed budget spreadsheet can be used or the Program may elect to use its own budget worksheet, however, the Personal Services (Salary and Wages) information provided by the organization must include: name of position to be funded, projected monthly salary, percent of time on grant, and number of months on grant for each position that will be funded with grant funds.

NOTE: Please use the rubric to make sure you include all the necessary components in the Statement of Work that will be reviewed by our IDPH Grants' Review Committee.

Name of Grant Program _____

Legal Name of Applicant _____

Section 8. APPLICANT CERTIFICATION

Under penalty of perjury, I certify that I have examined this application and the document(s), proposal(s), and statement(s) submitted in conjunction herewith, and that to the best of my information and belief, the information contained herein is true, accurate, correct, and complete. I represent that I am the person authorized to submit this application on behalf of the applicant, and that I am authorized to execute a legally binding grant agreement on behalf of the applicant if this grant application is approved for funding.

I, hereby release to IDPH, the rights to use photographs and/or written statements of information, regardless of the format, contained in or provided after the grant application for the purposes of publication on the IDPH web site, unless the applicant submits a written request asking that the information not be disclosed.

Signature

Printed Name/Title

Date

FOR DEPARTMENT USE ONLY - DO NOT WRITE BELOW THIS LINE

Type of Grant Application

- Direct Appropriation
- Allocation by Administrative Rule
- Competitive Request for Application
- Statutory Board Review Required
- Formula and/or Caseload Allocation
- Non-Competitive

Funding Source:

- General Revenue Fund
- State Special Fund
- Federal

Grant Application Funding Recommendation by Division/Program:

| | |
|--------------------------|--|
| <input type="checkbox"/> | Grant Application Disqualified/Not Eligible for Funding under this Award |
| <input type="checkbox"/> | Grant Application Recommended for Funding at Full Request |
| <input type="checkbox"/> | Grant Application Recommended for Funding at \$_____. |

Division Chief/Program Manager: _____ **Date:** _____

Grant Application Funding Recommendation Approved by:

Deputy Director _____ **Date:** _____

Grants Review Committee Score: _____

(Full review grants only)

Assistant Director _____ **Date:** _____

For agencies requesting administrative funds, budget forms must be completed and included with the grant application. Budget forms can be found at http://www.idph.state.il.us/pdf/Budget%20Forms_DRAFT.xls.

Budget and Justification

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

**DENTAL SEALANT GRANT PROGRAM
GRANT AWARD REQUEST
(Fiscal Year 2012 — July 1, 2011 through June 30, 2012)**

Agency _____

County(ies) Served _____

Address _____

Contact Person _____

Phone _____ Fax _____

E-Mail _____

| | |
|------------------------------------|-----------------|
| Patient Care | \$ _____ |
| Equipment (new grantees – \$7,500) | \$ _____ |
| Administrative Award Request | \$ _____ |
| TOTAL Award Request | \$ _____ |

List subcontractor(s) on the Public Health Grant Application, Section 5. **Include copy of contract(s) as an attachment.** 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.

- Protocols in Place:
- | | | |
|-------------------------------|------------------------------|-----------------------------|
| Patient Referral | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| All Kids Outreach | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medicaid/All Kids Billing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Quality Assurance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Retention Rates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sealant Application Procedure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Oral Health Education | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Retention Rates: FY10 - Average Long-Term Retention Rate _____%

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

(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 serve children in Pre-K? Yes No
Do you serve children with special health care needs? 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)

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

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

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, for FY11, list all schools that you served and the number of children completed in each – noting either Medicaid or other. Use the 15 digit school code.

Timeline:

Provide a timeline indicating when the program will be in schools in FY12.

Narrative:

Address any significant success, challenges, or changes only.

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

Target Schools

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

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 and 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 2012

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 # _____

Billing Month _____

Date Submitted _____

SEALANTS _____ @ \$36.00 = \$ _____
 (Total # of permanent 1st & 2nd 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 _____
 # of DSGP children _____
 # of Medicaid/All Kids children _____
 # of other children (other funding) _____

TOTAL # OF SEALANTS APPLIED _____
 # of DSGP sealants _____
 # of Medicaid/All Kids sealant _____
 # 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.)

DSGP Child

Medicaid

Attachment F

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

Agency Name _____

Child's Name _____
(Last) (First)

Child's Address _____

Date of Birth ____/____/____

Race: White Black Asian/Pacific Islander

School Name _____

School Code _____
Region County District School Type

Sealants Present: Yes No *(Prior to exam — 1st 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 ½ 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)

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 & 4)</i> | Retention Rate <i>(Column 5 divided by Column 2 X 100)</i> |
| | | | | | % |
| | | | | | % |
| | | | | | % |
| | | | | | % |
| | | | | | % |
| | | | | | % |
| | | | | | % |
| | | | | | % |
| Column 6 Total | | | | | % |
| Overall Program Retention Rate - Column 6 total divided by # of entries in column 6 = | | | | | % |

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 & 4)</i> |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| TOTALS | | | | |
| Retention Rate - Divide total of Column 5 by total of Column 2 then multiply by 100 = | | | | |

School "Eligibility"

_____ Number of schools Eligible (All in your jurisdiction: public, private, special, grade center, elementary, middle, intermediate, junior high school, high school) – FY12

_____ Number of schools Selected (Your criteria) – FY12

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 FY11

_____ Number of Schools Served in FY11

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: