Great Lakes Bay Health Centers
SMILES ARE EVERYWHERE
Mobile Dental Program
989-921-4393

Principals and school administrators appreciate the service we provide. When asked what do they like best about our program, *"Everything! Such a great service to our children. We appreciate you so much. Cannot say enough good things about your staff and service. Thank you!!"*

Dear Parent/Guardian:

Great Lakes Bay Health Centers (GLBHC) Mobile Dental Program, Smiles Are Everywhere, will be coming to your child's school to provide preventive dental treatment: *prophylaxis (cleanings), oral exams, fluoride treatments, and (sealants—dependent upon age of child)*.

Name of School: Beaverton Junior / Senior High School **Dental Bus Date(s):** November 2, 3, & 4, 2022

Smiles Are Everywhere is Great Lakes Bay Health Center's (GLBHC) Mobile Dental Program.
GLBHC has three state of the art mobile dental units (dental buses) with licensed dental providers providing preventive dental services to school-age children throughout the Great Lakes Bay Region and beyond. GLBHC's newest dental bus offers increased access to care with the use of a built-in wheelchair accessible lift. *Please call our offices in advance if your child will need access to the lift; we will ensure the correct mobile unit arrives at the school.*

Convenience is key, we travel to you!
Parents do not have to be concerned about taking their child out of school to take them to the dentist, as preventive dental care is provided directly at the school in the mobile dental units. Our dental providers and staff create a welcoming environment to children of all ages.

Preventive Dental Services
GLBHC's licensed dental providers provide prophylaxis (cleanings), oral exams, fluoride, and (sealants, dependent upon age of child).

Knowledge is Power
Oral health presentations are conducted in every classroom, educating the students about the importance of brushing and taking care of their mouth and teeth.

Dental Report Card
Following up with parents/guardians is important to us. A dental report card will be sent home with your child listing all dental services received and explaining the need for continuation of care. Establishing a 'Dental Home' is very important to your child's oral health. If further treatment is necessary, we encourage you to promptly schedule an appointment with your child's dentist or at one of our dental centers, listed on the dental report card.

Everyone is Welcome
GLBHC accepts most forms of dental insurance and will bill the insurance company for dental treatment provided. *Please send a copy of your child's insurance card. If your child has received treatment from their dental home, obtaining duplicate services could affect their dental benefits if also received on the mobile unit.*
Looking to lower the cost to $40.00? Apply for a Sliding Fee Discount; complete and sign the Application for Sliding Fee Program on reverse side of this letter (based upon gross household income and family size). Available to uninsured and underinsured patients. Payment collected prior to services rendered.

No insurance? Please call us at (989) 921-4391 and we can connect you with a Community Health Worker.

How to Participate
Parent or Guardian will need to complete the consent form on the reverse side of this letter (make sure to sign where signatures are required). Your child may return this form back to their teacher. Dates the dental bus is arriving to your child's school is listed above.

Respectfully,

The Mobile Dental Team

Great Lakes Bay Health Centers
Smiles Are Everywhere Mobile Dental Program
501 Lapeer Avenue
Saginaw, MI 48607

Phone: (989) 921-4393

24 Hours Emergency Number (989) 776-5394

Great Lakes Bay Health Centers
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THE DENTAL BUS IS COMING TO YOUR CHILD'S SCHOOL!

Patient Name: _____ Grade: _____ Teacher Name: _____

Birth Date: ___/___/___ Gender: ☐ Male ☐ Female Email Address: _____

Address: _____ City: _____ Address is: ☐ Temporary ☐ Permanent

Zip Code: _____ Home Phone Number: _____ Cell Phone Number: _____

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian ☐ American Indian/Alaska Native
☐ Asian ☐ Other Pacific Islander ☐ More than one race ☐ Refuse to report

Are you Hispanic/Latino?: ☐ Yes ☐ No ☐ Refuse to Report Is English your primary language?: ☐ Yes ☐ No

Are you or a family member a Migrant or Seasonal Farmworker?: ☐ Yes ☐ No

Guardian Information
Name: _____ Phone Number: _____ Birthdate: ___/___/___ Relationship to Patient: _____

Emergency Contact
Name: _____ Phone Number: _____ Relationship to Patient: _____

Dental Insurance: _____ Medical Insurance: _____ Subscriber Name: _____

Insurance ID #: _____ Subscriber Birthdate: ___/___/___ Relationship to Patient: _____ Subscriber Employer: _____

Our Federal Funding requires we ask income of all our patients. Your name/identity is not used in any of our reports.
This information also helps us determine if you qualify for our payment assistance program (Sliding Fee).

Household Income $_____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annual

How many people in the household does this income support?: _____

In order to qualify for a Sliding Fee, you must:
1. Complete the "Application for Sliding Fee Program" below.
2. Write all the names and ages of persons residing in the household. **(Signature required)**

To be completed by Staff only.
GLBHC Sliding Fee Category: _____
Staff Signature: _____
Date: ___/___/___
☐ Mobile Slide ☐ Standard Slide
GLBHC Site: Mobile

Application for Sliding Fee Program

Total 'Gross Annual' Household Income from all Sources: $_____
(Including Wages, Social Security, Public Assistance, Unemployment, Pension Payments, Alimony, Child Support or Other Cash Income)

Name Persons Residing in Household	Age	Name Persons Residing in Household	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

******Total Number of People in Household _____

I declare that this information relative to my total household income and family size as stated above is true and factual.

Head of Household/Authorized Person Name: _____

PLEASE SIGN HERE Head of Household/Authorized Person Signature: _____ Date: ___/___/___

Medical History (Please check Yes or No)
Allergies (other) type: _____ ☐ Yes ☐ No Asthma: ☐ Yes ☐ No Seizures: ☐ Yes ☐ No
Allergies (medications): _____ ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Other Medical Conditions/Medications: _____
Heart Problems type: _____ ☐ Yes ☐ No Is pre-medication needed for dental procedures?: ☐ Yes ☐ No

By signing this consent form and selecting "YES", I certify that I am the legal guardian and legal custodian of the student named above. I give my consent for the above named student to receive all services, listed on the front of this consent form, provided by Great Lakes Bay Health Centers Mobile Dental Program. I understand that treatment may be obtained at the patient's dental home rather than the mobile dental facility and that obtaining duplicate services at a mobile dental facility may affect benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits. I authorize GLBHC's Mobile Dental Program to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both GLBHC and my child's dentist to exchange health care information for the purpose of continuity and coordination of care. By selecting "NO" and signing this form, my child will not be treated. I understand that I may withdraw my consent for services upon written notice to GLBHC's Dental Department at any time. Make sure to read and complete both sides of this form before signing.

☐ Yes, I give permission to have my child receive dental treatment from GLBHC's Mobile Dental Program.

☐ No, I would not like my child to receive dental treatment from GLBHC's Mobile Dental Program.

Patient/Guardian Name: _____

PLEASE SIGN HERE Patient/Guardian Signature: _____ Date: ___/___/___