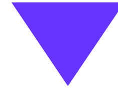
Community Ministries
Florida Baptist Convention
6850 Belfort Oaks PL
Jacksonville, FL 32216
800.226.8584, extension 3133

Florida Baptist Convention | *Right Beside You.*



Mobile Dental Unit

Planning Manual

Because We Care...

Revised for 2019
A Cooperative Program Ministry of the Florida Baptist Convention

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The King will reply, " I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me." Matthew 25:40 NIV

The Mobile Dental Unit is a ministry owned and operated by Florida Baptists. Southern Baptist churches throughout Florida have made this ministry possible as they have given to missions through the Cooperative Program and the Maguire State Missions Offering. The Mobile Dental Unit has been assigned to Community Ministries of the Florida Baptist Convention.

The Mission of the Florida Baptist Convention is to support local churches in their mission of making disciples of all nations through the Gospel of Jesus Christ.

Community Ministries wants to be 'Right Beside You', the local church, as you reach out in your community. The Mobile Dental Unit is a great resource that enables the local church to accept a greater role in meeting community needs. Community Ministries is concerned with the spiritual needs as well as the physical needs of all people. We hope that the Mobile Dental Unit Ministry will assist the local church in making disciples through the Gospel of Jesus Christ by giving special attention to their health needs.

Community Ministries desires to serve with you as you reach out to your community with the gospel of Jesus Christ. We, as Florida Baptists, are a team with a great desire to make a difference in the lives of people.

We have a great partner in the Florida Department of Health as we work together to meet the physical needs of the disadvantaged in Florida. Through the Volunteer Health Care Provider Program we are protected by State Sovereign Immunity. Regional Coordinators provide training and assistance.

You will be in our prayers as you minister through the Mobile Dental Unit!

Marc Johnston,
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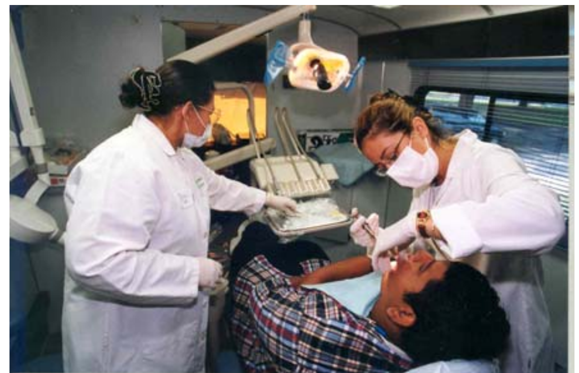

Mobile Dental Unit Ministry Team

The Ministry team Concept has been developed in an effort to make the Mobile Dental Unit user-friendly. We want you, the Church or Association, to be able to customize a dental project that will meet your needs and the needs of the people you are trying to reach. We want you to be able to see as many patients as possible while the Unit is in your area.

Our Team members are very passionate about the dental ministry and very compassionate towards all people.

The MDU Coordinators are available to help you plan your project. An important member of our team is the Transportation/Maintenance Coordinator. All of these are highly qualified and are volunteering their time.

The Mobile Dental Unit Ministry Team has the responsibility of keeping the Unit fully prepared to receive the health care professionals and patients. It is their job to make sure the operation of the vehicle and equipment run smoothly.

Jennifer Smith, Lead/Purchasing Coordinator

Beckie Layman, MDU Coordinator

Dr. Al Warren, Dentist of Record/Consultant

Dr. Jennifer Martinez-Amores, Consultant

Farrell and Crystal Crews, Transportation and Maintenance

For Personal Information please contact:
Marc Johnston, Community Ministries Catalyst
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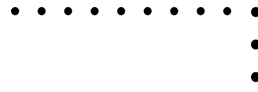

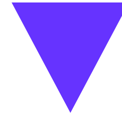

Steps Toward an Effective Project

Introduction

Planning is imperative for an effective project. Planning leads to good organization. What is organization? A good definition of organization is "placing yourself in the best possible position to be used by the Holy Spirit."

Listed below are proven steps toward an effective project. We realize that each project is unique and has different needs. The list of team members and duties is a suggested list. These can be shifted around to various team members. Every project is required to have a Project Director and every Project Director needs trained team members to make it an effective project.

Plan Ahead

A. Reserve the unit for your ministry:

The request to reserve the unit should be made through *Community Ministries* of the *Florida Baptist Convention.* The Mobile Dental Unit is in high demand. You can schedule the unit 2 years in advance.

B. Budget the costs

The Florida Baptist Convention Community Ministries budget will provide for the dental supplies, maintenance and repair of the unit and continual upgrading of the equipment. The church or association is asked to provide for the on-site expenses (housing and meals) of the Mobile Dental Unit Coordinators. The Coordinators operate the unit and assist the church or association during the project.

Plan Ahead!

- ***Reserve the unit for your associational ministry.***
- ***Budget the costs.***

Select a Planning Team

A. Enlist team members

This team should begin meeting approximately seven (7) months prior to your project. The following is a **suggested** list of team members:

Director of Missions, Church Pastor, or Designee
Project Director (can be a layperson)
Assistant Project Director
Patient Care Coordinator
Consultant, preferably a dentist for a dental project
Logistics Coordinator
Medical Screening Team (nurses preferred but not required)
Dental Resource Information Collector
Meal Coordinator
Advertising Coordinator

B. Review Specific Duties of Team Members

The following is a *suggested* list of specific duties for each team member:

1. Director of Missions, Association staff, Pastor, Church Staff Member, or Designee

- Gives overall supervision and guidance to the project
- Serves as a liaison between the church or association and the Florida Baptist Convention
- Arranges for the scheduling of the unit to come to the church or association.
- Arranges for money to be appropriated for the project through the associational or church budget.

2. Project Director

- Provides general supervision to the project (refer to Conducting Project section).
- Leads the team to assure commitment and response of dentists, dental assistants, nurses, and other personnel.
- Relates to the Volunteer Health Services Regional Coordinator (VHSRC) for training of volunteers and completion of forms for Sovereign Immunity.
- Serves as the liaison between team and the contact person at the location where the project is to be conducted.
- Assumes responsibility for the completion of all forms that are to be forwarded to the Florida Baptist Convention and to Volunteer Health Services Regional Coordinator.
- Leads in an evaluation of the project.
- Should have completed the screening and training process as required by the Department of Health to be designated as a DOH 110 volunteer.

Select a Planning Team

- ***Enlist Team Members.***
- ***Review Specific Duties of Team Members***

3. Assistant Project Director

- Assists in the coordination of the work of the team.
- Verifies that each patient seen on the unit completes an application for eligibility and a clinic medical form before an appointment is given.
- Assumes responsibility for the recruiting and scheduling of volunteers to work in the project.
- Recruit or serve as meal coordinator.

4. Patient Care Coordinator

- Provides witnessing and spiritual care training for all volunteers.
- Assumes responsibility of recruiting and scheduling spiritual care givers.
- Provide a comfortable and welcoming setting for waiting patients.
- Assures that all supplies are available for special activities with children (such as arts and crafts supplies, games, video, etc.)
- Arranges for dental kits to be available and distributed.

Conduct Meetings

A. **Initial Team Meeting**
Upon request and as schedules permit, the Community Ministries Catalyst or the Mobile Dental Unit Coordinators will meet with the team for training.

The team will need to discuss/review the following:

- The dates set for the project to assure everyone is in agreement
- Ways to recruit dental professionals and volunteers
- Specific responsibilities of team members and volunteers
- Requirements and forms needed for Sovereign Immunity
- Suggested screening procedures
- Helpful hints for conducting the project
- Forms that need to be completed before, during and after the project
- Plans for witnessing and spiritual care during the project
- Plans to make patients feel welcome and comfortable.
- Agreement for further care in case someone experiences pain or infection after the close of the project.

B. **Meet with the Volunteer Health Services Regional Coordinator (VHSRC)**

1. The project director needs to contact the Volunteer Health Services Regional Coordinator at the Department of Health at the beginning of planning your project. This person will provide the forms needed for Sovereign Immunity and can offer suggestions in the recruitment of dentists. This initial meeting should take place **at least seven months prior to the project**.

   List of Forms you will receive from the VHSRC/DOH:
   - VHCPP Application—for dentist
   - VHCPP Contract (After the application process is completed. This will need to be renewed every 5 years)
   - Chapter 110 Volunteer Application Packet
   - VHCPP Financial Eligibility Form
   - VHCPP Patient Referral Form
   - VHCPP Special Event Report—to be completed at the end of the project

2. **It will be necessary that those volunteers who will serve as the DOH 110 volunteers meet with the Volunteer Health Services Regional Coordinator for training prior to the project. All volunteers must also be trained in HIPAA (Health Insurance Portability and Accountability Act). The VHSRC will conduct the training 7 to 10 days prior to the screening day.**

Conduct Meetings
- ***Initial Team Meeting***
- ***Meet with the Volunteer Health Services Regional Coordinator (VHSCR)***

Determine the Location

A. The location for the project should be based on need. The following are some possible sites:
   - Churches
   - Schools, Shelters and other Institutions
   - Migrant Camps
   - Low Income Communities
   - City Housing Projects

B. The location must be accessible to power hookups.

   If an outside source is used, be sure breakers are heavy enough to carry the load.

The hookup needs to be for a 220/60 AMP Circuit Breaker/ 50 AMP plug

(**see picture of recommended plug for the unit**) or access to a panel where a breaker can be set.

The **Project Director** will need to check the plugs and hook-up for each site. Do not assume they are okay. **Electricity needs to be available 24 hours a day while the unit is at the project.**

Please Note: This is NOT an RV plug and you should *not* go to a RV supply store to purchase the plug. The plug can be found at Lowes or Home Depot.

Determine the Location
- ***Based on need.***
- ***Power hook-up accessibility***
- ***Water hook-up accessibility***
- ***Level ground for 40 foot bus.***

C. The unit also has a 100 foot electrical cord available for use. The unit must be parked close enough to the plugs for the cord to reach. The power hook-up is located on the left rear side of the unit. Consider this when choosing the location in relation to your power source.

D. The unit also needs to be accessible to water hookups. It has a 100 foot water hose. If more length is needed, arrange to have the extra amount of hose available to reach your water source.

E. The Location needs access to a sewage line or tank for waste (grey) water disposal.

F. The location must have a level spot for the unit to be parked. The unit is a 40 foot long bus.

G. The location should have parking availability for volunteers and patients.

H. The location should have a comfortable place for waiting patients.

Determine the Project Schedule

The project schedule should be determined based upon the time availability of your target population. If your daily schedule exceeds eight hours, you **MUST** recruit additional volunteers (*dental assistants, hygienists or nurses) to supplement the MDU Coordinators.

If the project is scheduled for a full, 8 hour day; a one-hour mealtime break should be scheduled for MDU coordinators. If the dentists are scheduled back–to-back, recruit additional volunteers (*dental assistants, hygienists or nurses) to cover for the MDU coordinators while they take their break.

*Additional Volunteers

We would love to have additional volunteers to serve on the Mobile Dental Unit with us. Reasons for Additional Volunteers:

- •Heavy Patient flow expected
- •Your Day exceeds 8 hours– MUST Recruit additional volunteers
- •Dentist/ or Project is not providing a Dental Assistant or Chair Assist.

Dental assistants, dental hygienists and nurses are ideal. They already have the skills needed to be effective. Other volunteers are accepted. All need to be trained. Everyone serving on the MDU must have a Hepatitis Immunization for their protection. The County Health Department provides this immunization.

Purpose of the Additional Volunteers:

- •Allows more patients to be treated.
- •Ease the work load of the MDU Coordinators.
- •Opportunity to serve in dental ministry.
- •Trained to be used in future ministries.

If you are using additional volunteers because your daily schedule exceeds eight hours, please contact CM Catalyst (Marc Johnston). Volunteer will need to be trained on the first day of the project. We may want to provide an opportunity for the volunteer to be trained on a project prior to your project.

Determine the Project Schedule

****Additional Volunteers***

Forms to Send to the Florida Baptist Convention:

- ***Team Information***
- ***Final Checklist***
- ***Schedule for Dentists and Health Professionals***
- ***Listing of Dentists and DOH 110 Volunteers***

Send Forms to the Florida Baptist Convention

Send the Following Forms to Community Ministries. These are found in the **FORMS** section toward the back of the Manual.

A. **Team Information Form** (PAGE 33)- This form lists the project contact persons. Send this form as soon as the project director is enlisted.

B. **Dentists and Dental Assistants Schedule**– Our MDU coordinators make their travel plans according to this schedule. ***Please send in 3 weeks*** before the scheduled start date of your project.

Please, email forms to mjohnston@FLbaptist.org or Fax to (904) 396-7712

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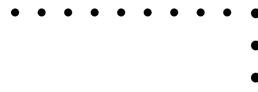
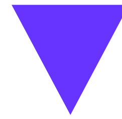




Planning for the Dental Project

Time Line for Dental Project

Phase One…. **6 months before Project Date**

- **Send *"Team Information Form"*** (found on page 33) **to the Florida Baptist Convention.**
- **Make initial contact with Volunteer Health Services Regional Coordinator**.
- **Begin process of enlisting dentists, dental assistants, volunteers and other personnel**.
- Determine target locations and meet with appropriate person(s) related to the location in order to gain permission to conduct the project.

Phase Two…. **3 months before Project Date**

- Enlist individuals to serve as DOH 110 Volunteers
- Complete the enlistment of dentists, dental assistants and volunteers and assign specific days, times and location.
- Send list of Dental Volunteers to VHSRC
- Begin preparation of dental kits

Time Line For Dental Project

Phase Three…. **2 months before Project Date**

- Decide on forms and materials that will be needed.
- Visit clinic locations to discuss the availability of water and electricity and to decide on screening procedures.
- Begin to publicize the project in associational and church newsletter to enlist additional volunteers.

Phase Four…. **1 month before Project Date**

- Have dentists complete the ***VHCPP Dental Contract Application*** and submit them to your Volunteer Health Services Regional Coordinator's office.
- Send in the ***Schedule for Dentists and Dental Assistants*** to Community Ministries and VHSRC
- Send a reminder card to the dentists with location, directions, and time.
- Provide witnessing/spiritual care training for volunteers.
- Arrange for post appointment care.
- Make sure all forms are duplicated as needed.
- Determine housing and meal arrangements for the Mobile Dental Coordinators, and contact them.
- Determine the supportive ministries for the children, such as puzzles, crayons, singing, videos, etc.

Phase Five…. **2 weeks before Project Date**

- Schedule a session with DOH 110 Volunteers and the Volunteer Health Services Regional Coordinator for training and to fill out forms. ALL volunteers will need to have the HIPAA/ Eligibility/ Referral training.
- Conduct screening and make appointments for patients to see the dentist(s). Give each patient an appointment card.
- Confirm arrival time of MDU
- Make sure dental kits are ready for distribution.

Phase Six…. **Completed by 3 weeks post completion of Project**

- Send Thank-You letters to dentists/dental assistants
- Complete and submit Dental Summary Report
- Complete and submit Evaluation Form

Recruit the Dentists and Dental Assistants

A. Recruit dentists at least 6-7 months prior to the project. Dentists schedule appointments in their office 6 months in advance, so you must enlist them early.
   1. Suggested form to use to collect Dentist information can be found on page 32

B. Ideas for recruiting dentists and dental assistants.
   1. Enlist a local dentist to help you recruit the other dentists for the project.
   2. Send a letter to the dentists and include the following: (sample letter provided on next page to be used with recruitment brochures)
      - Dates and shifts of the project
      - Florida Baptist Mobile Dental Unit is one of the affiliate agencies of the Project: Dentists Care, a project of the Florida Dental Association
      - Dentists may obtain one continuing education credit per one hour of patient services on our unit. Dental Hygienists, serving as dental assistants are also eligible for continuing education credits.
      - Share with the dentists that our patients are those who are uninsured and have incomes at or below the 200% poverty level.
      - Dentists can be protected by Sovereign Immunity
      - State that the dentist will need to bring a dental assistant to chair assist.
      - Enclose a card for a response
      - Include a brochure from the Florida Baptist Convention describing our Mobile Dental Unit Ministry. (Brochures and sample recruitment letter in word docx provided upon request.)
   3. Follow-up the letter with a phone call or visit the office personally to enlist the dentist.
   4. Does your county have a dental association? If so, contact the President of the Dental Association to see if you can make a short presentation about the project.
   5. The Volunteer Health Services Regional Coordinator can provide lists of dentists in the area and dentists who are already contracted with Sovereign Immunity, can provide ideas on how to recruit and who to contact.
   6. In the Resource section dentist and dental assistants are listed. These have said they are willing to volunteer. Contact the ones in your surrounding area.

Recruit the Dentists and Dental Assistants:
- ***Recruit dentists at least 6-7 months prior to the project.***
- ***Ideas for recruiting dentists and dental assistants***
- ***Follow-up with a call, visit or card to confirm location and time for their commitment***

C. When a dentist is enlisted, follow-up with a call, visit or card to confirm the location and time for their commitment. Include directions to the project. Call one week before the project as a reminder.

D. Dentists for referral:
   - Make Arrangements for referral of patients to an oral surgeon/dentist for emergency situations.
   - Research area for dentists and clinics where patients can be referred for additional work.

E. Non-Florida licensed dentists can be used. This helps greatly since there are many retired out of state dentists living in Florida. It can be a lengthy process, so start early. Contact the Board of Dentistry (850) 245-4444 or visit http://www.floridasdentistry.gov/licensing/limited-dentist-license/

F. Project Dentist Care (PDC)- Florid a Baptist Convention is an Associate Member
   - PDC Resource Guide lists minimal payment dental services by county– http://www.floridadental.org/foundation/programs/project-dentists-care
   - use for Referrals and Recruiting

Date

Dentist Name
Address
City/State/Zip

Dear Dr. ____________,

I would like to introduce you to an opportunity to serve people in need in our community. We will be working with The Florida Baptist Mobile Dental Unit and offering dental services to residents of (your targeted community). (your church or association) is hosting the Mobile Dental Unit at (your project location) the week of (your project dates). There will be up to three shifts (morning, afternoon, evening) each day. We are hopeful that you will be able to help us this year with one or more of the available shifts. Without your help and generosity this project will not be possible.

I know that you schedule routine patient exams/cleanings several months in advance and we want to maximize your involvement with little to no interruptions to your practice. With that being said, we would like to begin scheduling dentists and dental assistants as soon as possible for that week. Once again, we need your help and will accommodate any day and shift that you are available to help.

We want to serve the maximum number of patients and will make appointments after a dental pre-screening/ consultation is done to help us schedule according to the need (as best as we can determine). If you are not familiar with the Florida Baptist Convention Mobile Dental Unit, please contact us for additional information or you can access information at:

https://flbaptist.org/florida-baptist-mobile-dental-ministry/

Please, check the available morning-afternoon-evening shifts on the attached form and indicate which shift(s) you are willing to volunteer your services and we will schedule patients appropriately. We will send out updates as shifts are requested. Usually only 2 shifts are scheduled each day. Also, please indicate if you will be able to bring 1 or 2 assistants with you during your shift.

Available Shifts

Monday (Month,Day) Morning 8am-12pm, Afternoon 12pm-4pm, Evening 4pm-8pm
Tuesday (Month,Day) Morning 8am-12pm, Afternoon 12pm-4pm, Evening 4pm-8pm
Wednesday (Month,Day) Morning 8am-12pm, Afternoon 12pm-4pm, Evening 4pm-8pm
Thursday (Month,Day) Morning 8am-12pm, Afternoon 12pm-4pm, Evening 4pm-8pm
Friday (Month,Day) Morning 8am-12pm, Afternoon 12pm-4pm,

*(*NOTE* This is a sample, please provide the shifts that you have determined to meet your community needs)*

Once again, thank you in advance for your willingness to serve those in our surrounding communities in need of dental care.

Respectfully,

Name
Title

sample

Scheduling the Dentists

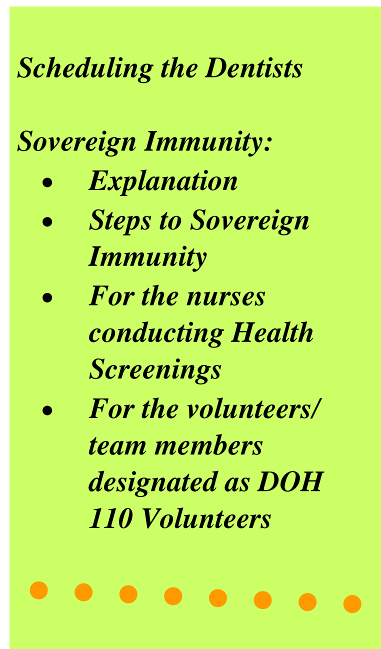
Schedule each dentist to work in a 3 to 4 hour shift. If a dentist wants to work more than one shift, schedule him for an additional shift. Some Dentists choose to work all day. Schedule the dentists for patients appropriate for his skills. If you schedule the dentists to work on children, make sure the dentists is prepared to see children.

Sovereign Immunity

A. Explanation

The Florida Baptist Convention has been providing free dental care for indigent Floridians since the early 1970's. We have been most fortunate through the years that we have never encountered a lawsuit because of our volunteer health care services.

In an effort to increase health care access for indigent Floridians through volunteerism, the 1992 Florida Legislature passed the *Florida Health Care Access Act* that created *section 766.1115, Florida Statutes, the Volunteer Health Care Provider Program.* The intent of this program is to increase health care volunteerism through the extension of Sovereign Immunity protection. This means that the state of Florida would assume responsibility for liability if the dentist, church, association, or state convention were ever involved in a lawsuit as a result of treatment received on the mobile dental unit.



However, certain guidelines and processes must be followed as outlined by the Department of Health and the Volunteer Health Services Program. The staff and attorneys of the Florida Baptist Convention have determined that it is feasible that we enter into an agreement so that our entities are protected from any possible lawsuit.

B. Steps to Sovereign Immunity

1. Each church or association project director will want to contact their Volunteer Health Services Regional Coordinator (listed in the Resource Section) at the beginning of the planning process. The Regional Coordinator will help you with the process, training, and provide the forms for Sovereign Immunity. The Regional Coordinator will also provide training for HIPAA. (refer to the next section).

Sovereign Immunity (continued)

For the Dentists

New or Inactive Dental Providers will need to complete a **Dentist VHCPP Contract Application**. The Project Director will need to contact the dentists to complete these forms. We highly recommend that you type in as much information as possible before you take the form to the Dentist. After the dentist has signed it, send it to the VHSR Coordinator. A Contract will be drawn to be signed by the Volunteer Dentist and the Health Department Director/Administrator. A copy of the contract will be provided to the Project Director.

Contracting Process should be completed 4 weeks prior to the project.

* *The **Dentist Contract** will need to be renewed every 5 years*. The Application can be found on page 33.

** The Project Director will need to submit the name and license number of each dentist that serves **per project** to the VHSR Coordinator, who will be able to tell the Project Director which Dentists need a current contract.

For the volunteers/team members designated as DOH 110 Volunteers

At the training session, the Volunteer Health Services Regional Coordinator will have all volunteers complete the **Volunteer Participation Roster.** New Project Directors and other new volunteers who serve as DOH 110 volunteer (financial screening) will complete the Chapter 110 Volunteer Application found on page 35. This will need to be completed and taken to your DOH training.

*Please, note: The Project Director needs to complete a 110 Volunteer Application Packet, which She/He will need to obtain from the VHSRC

HIPAA – Health Insurance Portability and Accountability Act

Effective April 14, 2003, The HIPAA Privacy Rule went into effect. HIPAA Privacy Regulations establish national standards for protecting the privacy of health information.

- *They impose new restrictions on the use and disclosure of protected health information.*
- *They give patients greater access to and protection of their medical records and more control over how they are used.*
- *Established safeguards to protect the privacy of health care information.*
- *Sets boundaries on the use and release of health records.*
- *Holds people accountable if they violate patient rights (civil and criminal penalties)*

How does this affect the Florida Baptist Mobile Dental Unit?

Patients must be given notice about their privacy rights. A **HIPAA Notice of Privacy Rights document must be posted where it can be easily read. Copies of the brochure should be available for patients if requested. The patient shall sign to consent and acknowledgement of HIPPA on the bottom of the Medical Record Form.**

HIPAA:

- ***Explanation of HIPAA***
- ***How does this affect the Florida Baptist Mobile Dental Unit?***

HIPPA (continued)

ALL DOH 110 Volunteers must be trained in the HIPAA guidelines by the Volunteer Health Services Regional Coordinator. Usually this is done when the 110 training is provided.

Guidelines to Protect Patient Privacy

1. It is recommended that once the patient's paperwork is completed by the DOH 110 Volunteer, that the paperwork be placed in a manila folder or envelope to protect the patient's privacy.
2. Volunteers may then take the folder to the coordinators on the unit. Patient should not carry record
3. Never Discuss Patient's information within hearing distance of others.
4. Be sensitive of discussing patient's information in confines of Dental Bus. (that patient's friend or relative may be in the other chair).

Recruit and Train Volunteers

A team of volunteers should be available during project hours. The team should consist of DOH110 volunteers, patient care volunteers, and the meal coordinator.

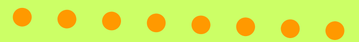
A. Each project is strongly encouraged to enlist 3-4 individuals who will serve as DOH 110 Volunteers. A DOH 110 Volunteer is required to be on site each day that the project is being conducted.

B. The DOH 110 Volunteer
   1. A volunteer who has completed the screening and training process as required by the Department of Health.
   2. Responsible for processing all the forms necessary for Sovereign Immunity/Patient Financial Qualification (forms provided by VHSRC).
   3. Helps patient complete Patient Medical Record Form

C. Patient Care Volunteers
   1. Greet the patient when they come on site and make them feel welcomed.
   2. Direct patients to check in at the waiting area.
   3. Mingle with patients and initiate conversations with them in an effort to get to know them and to provide a Christian witness and spiritual care.
   4. Provide activities for the children while they wait to see the dentist. It is helpful to have puzzles, crayons, paper or picture stories available. A volunteer may want to read Bible stories to the children or show a Christian video. Try to relax them prior to seeing the dentist.
   5. Use resources to educate patients with proper dental care.
   6. Hand out dental kits after the patient has seen the dentist and explain briefly who provided them.

Recruit and Train Volunteers:

- ***Team of volunteers for each shift***
- ***3-4 serve as DOH 110 Volunteers***
- ***Duties of DOH 110 Volunteer***
- ***Duties of Patient Care Volunteer***
- ***Meal Coordinator***
- ***Suggested Training Session for all Volunteers***



D. The Meal Coordinator
   There is limited time between each shift. It will be helpful to recruit a church each day to prepare and bring a meal for the dentist, dental assistant, volunteers and mobile dental unit coordinators. Be sure to coordinate the exact time with each church according to that day's schedule. **Schedule at least an hour for meal times between shifts.**

E. Suggested Training Session for all Volunteers
   1. Review purpose and dates for the project
   2. Assign each volunteer the specific day, time and location he or she will serve.
   3. Go over specific responsibilities of each volunteer.
   4. Provide training for spiritual care and witnessing.
   5. Have a time of prayer for the project, patients, health professionals and volunteers.

Collect Dental Kits

Items to include in the Dental Kits are as follows (place all items in a Ziploc bag):

1. Toothbrush (soft)
2. Dental Floss
3. Toothpaste (6.4 oz. Size)
4. Gospel Message—The planning team should decide on the Gospel message to be included in each kit. The New testament or the entire Bible is preferred.

Collect Dental Kits:

- ***Items to include in Dental Kits***

Pre-Project Communication with MDU Coordinators

A. **Prepare for MDU arrival**

The Project Director will need to communicate with the Transportation/Maintenance Coordinator on the location of the project. Someone needs to meet the MDU when it arrives to show where to park the unit and help with the set up.

B. **Prepare for MDU Coordinators**

- **Project Start Day and Time needs to be communicated with MDU Coordinators 2-3 weeks before the Project.**
- Church or Association is responsible for housing and meals.
- Project Director should discuss housing arrangements. As a suggestion, meet the coordinators when they arrive and take them to their housing.
- If you have them eat on their own, advance them funds at the beginning of the project. They will provide receipts and left over money at the end of the project. If you did not advance them enough funds, they will present receipts for reimbursement.
- MDU and Transportation Coordinator contact information is listed on page 2

Pre-Project Contact with MDU Coordinators:

- ***Prepare for MDU arrival***
- ***Prepare for MDU Coordinators***

Final Check List

Please, use this form as a check list for your project. Hopefully, this will help you in your preparation.

Final Checklist

Please check (√) the space when the task has been accomplished

- ❑ 1. Completely read the Mobile Dental Unit Planning Manual.
- ❑ 2. **Sent Team Information Form to Community Ministries**
- ❑ 3. 110 Volunteer Application Packet completed by Project Director and sent to VHSRC
- ❑ 4. All forms related to the DOH 110 Volunteers completed and sent to the Volunteer Health Services Regional Coordinator.
- ❑ 5. All forms related to sovereign immunity for dentists, dental assistants and nurses, completed and sent to Volunteer Health Services Regional Coordinator.
- ❑ 6. Training scheduled for the DOH 110 Volunteers with the Volunteer Health Services Regional Coordinator. Training date: ____________________
- ❑ 7. Target group determined and promotion has been completed.
- ❑ 8. Arrangements made for power, water, and sewage as well as a reasonably level place to park the Mobile Clinic. Proper access for patients and staff considered.
- ❑ 9. Have a plan for patients' screening and scheduling appointments one week prior to the project.
- ❑ 10. Materials in hand for medical or dental record keeping, HIPAA brochures and consent form and witnessing pieces.
- ❑ 11. Training of all volunteers conducted.
- ❑ 12. Arrangements made for referral of patients to an oral surgeon/dentist in emergency situations.
- ❑ 13. Communication relating to housing and travel schedule made with the Mobile Dental Unit and Transportation Coordinator.
- ❑ 14. Sent Dentist and Dental Assistants Schedule to Community Ministries and VHSRC

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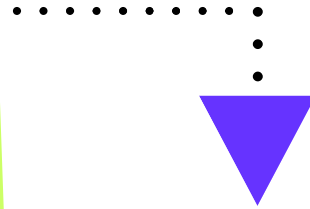
Florida Baptist Convention
6850 Belfort Oaks PL
Jacksonville, FL 32216
800.226.8584, extension 3133



Conducting the Dental Project

Conduct Screenings for Patients and Schedule Appointments

A. Screening and Patient Forms

1. When to Enlist Patients

   The enlistment of patients, 6 years of age and older, is done prior to the day of the appointment. The team should determine how and when this should be done. Enlisting and scheduling is usually completed within the week before the project begins and may continue throughout the project if there are openings in your schedule.

2. Financial Screening

   In order to be covered under Sovereign Immunity, we can only treat patients who fall at or below the 200% poverty guidelines.

   For medical clinics that use 150% for dental projects please request, in writing or via email, an exception to the policy from the CM Catalyst.

   A. The DOH 110 volunteer must complete a ***VHCPP Financial Eligibility Form*** for each patient. This is the form required by the Department of Health for Sovereign Immunity. The form is provided by the Volunteer Health Services Regional Coordinator. The DOH110 Volunteer must complete this form with the answers provided by the patient. The DOH 110 Volunteer AND the Patient must both sign the form at the same time and date.

   A. B. The ***VHCPP Patient Referral Form*** (Notice to Patient) needs to be read to the patient.. The DOH 110 Volunteer AND the Patient must both sign the form at the same time and date. This form is required by the Department of Health and must be completed by the DOH 110 volunteer. The form is provided by the Volunteer Health Services Regional Coordinator.

   Note: If the patient is seen a second time or at the private office of volunteer dentist, a new VHCPP Referral Must be generated.

   > ***Screenings for Patients***
   > - ***When to Screen Patients***
   > - ***Financial Screening***

3. Medical Screening

   If a patient qualifies, have him fill out the ***Dental Clinic Medical Record*** and sign it. You will find this form in the manual on page 39. Several forms will need to be duplicated prior to the screening. (If the patient has medical problems denoted on the medical form by an asterisk (*), a "Health Issues Authorization" Form (page 49) must be completed and signed by the patient's physician. If pre-medication is needed for treatment, the patient must get a prescription from his doctor.) The parent or guardian must sign the form if the patient is under 18 years of age.

   During the Medical Screening, you will record the patient Blood Pressure and Pulse Rate at the top left of the form. If the Medical Screening is conducted prior to appointment day, re-take Blood Pressure and Pulse Rate when the patient arrives, and record in the top right of the form.

Conduct Screenings for Patients and Schedule Appointments (Continued)

4. Dental Screening

Our primary purpose is to treat persons with primary dental needs. We only do fillings and extractions. Tell the patient that they will receive treatment to get them out of pain. We do not provide for cleaning or routine check-ups on our Mobile Dental Unit.

Preventive dental care is very important. Since we are not set up on the Mobile Dental Unit for cleaning, we highly recommend that you find a place in your County where you can refer patients. Some of the possibilities are a dental hygienist school or public health department.

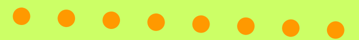
B. Schedule Appointments

1. At the time of screening, schedule appointments for each patient.
   - Schedule appointments every 30 minutes.
   - Encourage patients to arrive 45 minutes to an hour before appointments. Feel free to set the arrival time.
2. Begin each shift with two patients and two "stand-by"
3. Stand-By Policy
   After the appointments are filled, you may schedule patients to come on a "stand-by" basis. However, the patient will need to understand that you can not guarantee that they will be seen. If a scheduled patient does not come OR if the dentist is working faster than expected, it may then be possible for them to receive treatment. The "stand-by" needs to be on site and ready to board MDU when an opening arises.
4. **Schedule the last patient 30 minutes** before meal time and the close of the day.
   Optional Scheduling Method: If Volunteer Dentist is scheduled 8am-12:00pm; Schedule half the morning patients for 7:30 and the other half for 9:30.
   A. Check previous records for how many patients the Dentist has seen in a session. (average is 10-12)
   B. Inform patients to be prepared to wait 2 1/2 hours (the extent of the patients' needs may not be fully known until they are on the unit and have their x-ray and procedures can be complicated, so time for each patient will vary.)

- ***Dental Screening***

Schedule Appointments
- ***Schedule appointments for each patient.***
- ***Begin each shift with two patients***
- ***Stand-by Policy***
- ***Schedule the last patient 30 minutes before meal time and the close of the day.***

Reminders



C. Communication with the MDU Coordinator During Project:

1. **Have a Prayer time** each morning and share what happened the day before
2. Go over Patient Schedule for the day

- If evening sessions are scheduled, provisions should be made so that MDU Coordinator is Never left alone on premises at night. (allow 45mins-1 hour for clean up and preparation for the next day after the last patient is finished)

Creating Patient Records

Due to HIPPA Regulations, volunteers must be extra cautious with patient information. Feel free to develop your own color coding system to help with easy retrieval of patient records.
Some Items you may want to consider:

- Items from Medical History Authorization Form
- Language Groups
- Keep track of Witnessing Encounters

Use a Color Code System

Reminders

Important Reminders During the Project:

- **Church or Association is responsible for recruiting dental assistants. If a dentist does not bring an assistant, the local project is still responsible for providing a dental assistant.**
- Patient Care Volunteers should greet and direct the patients to registration area when they come on site (church, school, camp, etc.), Do not allow them to approach the unit without an escort.
- Patient Care Volunteers are responsible for escorting patients to and from the unit. Patient should Never carry their own record or exit alone.
- Remind patients to turn off cell phones before entering the unit.
- Make sure the Medical Record Form is complete before patient enters the unit.
- Project Directors should not leave site without checking in with the MDU Coordinators.
- At the end of the project, you will complete separate reports for the VHCPP and Community Ministries. Please, review the requirements prior to starting the project..

Meeting the Spiritual Needs

One of the main purposes of the Mobile Dental Unit is "to reach more people for Christ by giving special attention to their health needs". **The focus of the project should be on meeting the needs of the individual—dental as well as spiritual needs.** The whole project should be designed with intentional evangelism. Spiritual Care Training will be provided upon request.
Please contact Marc Johnston, Community Ministries Catalyst.

A. Set the atmosphere!

Have a "greeter" to welcome patients and direct them. Provide a sitting area for the patients. Volunteers should sit with the patient as the patient waits to enter the MDU. Some patients will be nervous about seeing the dentist. Comfort them! Be sensitive to them as well as the working of the Holy Spirit. You may want to set up a private area for counseling. Feel free to share your faith with the patients before and after they enter the MDU.

B. Have resources available!

Provide tracts and Bibles in the patient's language. Show the Jesus video or some other video that will share about the Christian faith. Make copies of *"Because We Care"* letter available to the patients. (see Resource Section)

C. Utilizing Witnessing Opportunities!

Actions speak louder than words but actions and words speak volumes. Your walk and talk can build relationships for sharing your faith. Be open and willing to listen; plant seeds.

Never pressure individuals to the point of implying that the person must accept Christ in order to receive help. Provide the needed assistance, and let the circumstances furnish the lead-in for personal witnessing. Use FAITH, CWT, Evangelism Explosion, the Roman Road, the ABC's of Salvation, or any other witnessing tool that you are trained to use. Normally disadvantaged persons appreciate prayer for their needs; therefore, a prayer may serve as a lead-in to personal witnessing.

Meeting the Spiritual Needs

- ***Set the atmosphere.***
- ***Have resources available***
- ***Utilizing Witnessing Opportunities***
- ***Lead questions/ statements to identify common ground***
- ***Example lead-ins***

Personal experiences often provide an appropriate opening for a testimony. For example:

(1) If a parent is having difficulty with the children, say something like *"parenting is difficult. I appreciate the fact that my mother took me to church from an early age."*

(2) If the recipient has complained of always moving, say something like, *"I've had to move several times; however, one strength I have found in every new community is the church."*

(3) If the person is at the point of tears, say something like, *"Let's just stop right now and ask God to help us with this really tough situation."*

(4) If the person is from another country or state unfamiliar to you, perhaps a response would be: *"I don't know much about your country/state. Tell me about it."*

(5) Lead questions/statements to identify common ground might be:
Where are you from?
What's your work?
Tell me about your family.

(6) Some lead-ins might be:
I can relate to that.
I remember when…
Before I became a Christian I…
Before you go, I'd like to talk with you about something that's important to me. (Share your testimony or witness briefly and sensitively.)

The message of salvation may be communicated by manner of life in sharing and caring, by word of mouth, and by God's written Word. Thus, we introduce Jesus Christ to people who normally do not attend church worship services. Every service opportunity is an occasion for personal witnessing, for opening doors to share Christ's love and salvation. Your offer of friendship, understanding and assistance will create witnessing opportunities. You give verbal witness as you provide the help.

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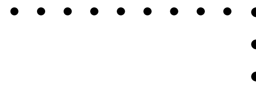

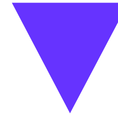

Finishing the Dental Project

Forms to be Completed After the Project

A. Complete the following forms and send to Community Ministries, Florida Baptist Convention: marc.johnston@flbaptist.org or fax (904)-396-7712

1. Dental Project Summary Report (Page 65)
2. Evaluation of Mobile Dental Project (Page 66)

B. Complete the VHCPP Summary Report Form and send to your Volunteer Health Services Regional Coordinator. The VHRSC will provide the form. (This can be done electronically)

C. Compile the patient records and complete the patient list and give them to the association or church. All patient records must be kept confidential and in a secure place for seven (7) years.

Forms to Complete After the Project

- ***Forms for Church & Community Ministries***
- ***VHCPP Reporting Form***
- ***Patient records***

Evaluate the Project
Follow-up on Prospects
Thank the Medical Personnel

Evaluate the Project

The planning team should meet together to evaluate the project from their perspective. Often the MDU coordinators will have helpful suggestions. Ask for their input prior to their departure. Make notes on changes you may want to make for the next project. Consider the spiritual impact of the ministry.

Follow-up on Prospects

Many of the patients will be prospects for your church or churches. Visit or call them. Let them know they are welcome to attend your church. See what their needs may be and how you can assist them. Build a relationship with them.

Hopefully, some of the patients will come to know Christ. Help them to see the need of following through in baptism and growing as a Christian. Invite them to be a part of your congregation.

Thank Dental Personnel

Send a thank you letter or card to the dentists and their assistants. Let them know how much you appreciate them and how valuable they are to the project. Include a stamped, self addressed card asking if they would commit to next year's project. You may want to consider a small gift of appreciation after the project or at another appropriate time during the year such as Christmas, etc. This will help build a relationship with the dentists and your project.

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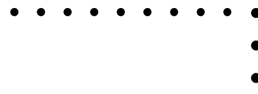

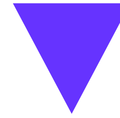

Forms to Use Before the Unit Arrives

- Team Information Form
- Dentist Information
- VHCPP Dentist Application
- Schedule for Dentists

Team Information

Note: Submit immediately after the team has been elected.

Church or Association: ______________________________ Date: ________________

Project Dates: ____

Tentative Locations: ____________________________ Address: ____________________

____________________________ Address: ____________________

PROJECT DIRECTOR: ____

ADDRESS: ____

PHONE: ____

E-MAIL ADDRESS: ____

ASSISTANT PROJECT DIRECTOR: ______________________________________

ADDRESS: ____

PHONE: ____

Number for Patients to Call: ____

SEND TO: **Florida Baptist Convention**
Community Ministries
6850 Belfort Oaks PL
Jacksonville, Florida 32216
Office Fax: 904-396-7712
E-mail: Mjohnston@flbaptist.org

Dentist/Dental Hygenist Info

Project:_____________
Project Date:__________

Please complete the contact information and indicate your 1st, 2nd, and 3rd choice for which shift you want to volunteer.

	Day Date:	Day: Date:	Day: Date:	Day: Date:	Day: Date:
8am to Noon					
Noon to 4pm					
4pm-8pm					

We will Provide a light meal for all volunteers prior to their shift

Contact Information: Dentist Dental Hygienist Dental Assistant
Name: ____
Address: ____
City: _________________________________ Zip: ___________
Email:____
Dental License # _____________________________________
Office Mgr. Name: ____________________________________
Office Phone: ___________________ Office Fax: ___________________
Cell Phone: ___________________

Preferences:

- [ ] Extractions Only
- [ ] Fillings Only
- [ ] Either

- [ ] Pregnant– 1,2,3 Trimester
- [ ] Blood Pressure Limit
- [ ] Children

Sovereign Immunity:

- [ ] I need
- [ ] I Already Have

Dental Assistant to serve with Me: ____
Phone:________________________________ Email: __________________________________
Address: ____
City: ____ Zip: ________________

Volunteer Health Care Provider Program (VHCPP)

APPLICATION FOR A VOLUNTEER HEALTH CARE PROVIDER PROGRAM CONTRACT

INSERT NAME AND LOCATION OF EVENT: ______________________________

Provider Name: ____
(Please Print) (Last) (First)

Address: ____
(Please Print) (Street) (City) (State) (Zip)

Phone Number: (__________) ________________ e-mail: ______________________
(Area code) (Please Print)

Occupation: ______________________________ FL License Number: ____________

Individual providers applying for a VHCPP contract for sovereign immunity protection that are affiliated with a Professional Association (P.A.), the Florida Department of Health recommends a sovereign immunity contract be established to protect the P.A.

Please indicate if you would like a contract for your affiliated Professional Association.

Yes______ No _______ Not Affiliated __________

Signature:________________________________ **Date:**________________

Printed Name of Professional Association: ______________________________

FEI or Document Number: ______________________________________

Printed Name and Title of Corporate Officer/Director with Contract Authority:

____

Business Address: ____
(Street) (City) (State) (Zip)

Phone Number: (____________) ________________________

TO PROTECT CLIENTS, A ROUTINE CHECK OF THE CORPORATION NAME AND PROVIDER'S PROFESSIONAL LICENSE WILL BE MADE THROUGH THE FLORIDA DIVISION OF CORPORATIONS AND THE FLORIDA DOH DIVISION OF MEDICAL QUALITY ASSURANCE.

License/Corporation Verification (For DOH Use Only)

Individual
Current Florida Health Professional License? Yes _________ No __________
License Status "Clear and Active"? Yes _________ No __________

Corporation
Active Florida Professional Association? Yes _________ No __________ N/A _________

Verification Completed By: ________________________________ ________________
Signature of VHCPP Regional Coordinator Date

Return application form to: Joyce.Coufal, Regional Volunteer Coordinator, Volunteer Health Services, P. O. Box 1305, Tavares, FL 32778 or Scan-Joyce.Coufal@flhealth.gov Fax 352-589-6492

sample

Dentists And Dental Assistants Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
MORNING	MORNING	MORNING	MORNING	MORNING
AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON
EVENING	EVENING	EVENING	EVENING	EVENING

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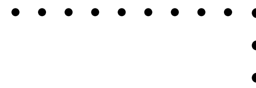

Forms to Use During the Project

- Dental Clinic Medical Record (English/Spanish/French)
- Health Authorization Form (English/Spanish/French)
- HIPAA Consent Form
- HIPAA Notices of Privacy (English/Spanish/ French)
- Volunteer Sign-In Sheet
- Post Surgery Instructions (English/Spanish/ French)
- Appointment Card and Additional Treatment Card (English/ Spanish/ French)

These forms may be copied as needed
and are available in other digital formats via request

DENTAL CLINIC MEDICAL RECORD
FLORIDA BAPTIST CONVENTION - CHURCH AND COMMUNITY MINISTRIES

BP _____/_____ Pulse:______ **BP _____/_____ Pulse:______**

Name:____ Age:________ DOB:______________

A. Do you (patient) have or had any of the following: Yes No

	Yes	No
Asthma *Bring your inhaler with you*		
Diabetes: Type 1 Insulin Dependent ( ) Type 2 ( ) *Eat Normal meal before appointment*		
***Epilepsy: Date of Last Seizure? ______________________**		
Heart Disease: Heart Attack ( ) Stroke ( ) Chest Pain ( ) *Valve Replacement ( ) *Valve Defect ( ) *Heart Defect ( ) Rheumatic Fever as a child ( ) Heart Murmur ( )		
***Blood Thinners (i.e. aspirin, baby aspirin, Coumadin, Plavix, etc.)**		
Pacemaker		
Kidney or Liver Disease (Dr.'s clearance required if you are on *Kidney Dialysis).		
Penicillin or other drug reaction		
Prolonged Bleeding after surgery or dental extractions		
Tuberculosis Date:________________________		
Sexually Transmitted Disease, Herpes		
High Blood Pressure		
Infectious Hepatitis (A, B, or C)		
***Artificial Joints (i.e. hip, knee, elbow)**		
HIV Positive, ARC (AIDS Related Complex), or Diagnosed with AIDS		
Allergies: Please list below (Latex?)		
***Cancer: Currently on Chemotherapy or Radiation**		
Fosamax or medication for Osteoporosis/Osteopenia		
Other pertinent information provider should be aware		

B. Have you ever experienced any unfavorable reaction from previous dental treatment? YES NO

C. Are you currently under the care of a physician? YES NO

D. Have you been hospitalized or in the Emergency Room in the last 2 years? Date:___________________ YES NO

E. Are you taking any medications? Please list below (continue on back if needed) YES NO

F. If female, are you *Pregnant? Trimester 1 2 3 YES NO

If you checked YES in parts A through E, explain here:____

____
____
____
____

Additional Remarks:____

***If you have any of these health issues, you must have a completed Health Authorization Form to be seen by a provider on the Mobile Dental Clinic.**

I consent to the____________________________________, located in _______________, the Florida Baptist Convention Mobile Dental Unit operators and any dentist or health care provider or authorized agent, examining or treating me to use or disclose my protected health information for diagnosis and treatment or health care operations, including any information received from other health care providers. This notice will be in effect for one year from date of signature. I understand this consent can be withdrawn.

I acknowledge the above and receipt of the Notice of Privacy Rights. I declare that the above medical information is accurate.

________________________________ ________________________________ ____________
Signature of Patient or Guardian **Signature of Dental Project Volunteer** ***Date***

Clínica Dental Información Médica

FLORIDA BAPTIST CONVENTION - CHURCH AND COMMUNITY MINISTRIES

BP _____/_____ Pulso: _______ BP _____/_____ Pulso: _______

Nombre: ______________________________ Edad:___________ Fecha de Nacimiento: ______________

A. ¿Tiene usted o ha tenido algunas de las siguientes enfermedades? Sí No

	Sí	No
Asma (por favor asegúrese de traer su respirador con usted)		
Diabetes Tipo 1 ( ) ¿se inyecta usted insulina? Tipo 2 ( ) coma normal antes de su cita médica.		
Epilepsia Fecha de su último ataque ( )		
Enfermedades cardiacas, ataques al corazón, dolor en el pecho, *Ha tenido algún reemplazo de válvula, ha sufrido de algunos problemas con su válvula cardiaca. Fiebre reumática de niño, problemas cardiacos		
*¿Toma usted algún anticoagulante para la sangre (Aspirina, Comodín, Plavix, etc.)?		
¿Tiene usted Marca Paso?		
¿Enfermedades en riñones o hígado? * Si usted está recibiendo diálisis*, esto debe ser aprobado por el doctor		
¿Es usted alérgico a la Penicilina o algún otro medicamento?		
¿Sangra usted fácilmente después de una cirugía o una extracción?		
¿Ha tenido usted Tuberculosis? Fecha: _______		
¿Ha tenido algunas enfermedades de transmisión sexual?		
¿Sufre de alta presión en la sangre?		
¿Hepatitis en forma A, B o C?		
¿Implantes de rodillas, caderas, codos etc.?		
HIV Positivo, ARC (AIDS enfermedades relacionadas), ¿Ha sido diagnosticado con el AIDS?		
Alergias: Por favor escriba: (látex?)		
Cáncer * Esta usted recibiendo Quimioterapia,		
¿Esta usted tomando medicina contra la Osteoporosis ? como Fosamax		
¿Alguna otra información pertinente que usted quisiera compartir?		

****Si usted tiene algún problema de salud, NECESITA tener permiso de su medico por escrito para que la persona encargada de la Unidad Dental pueda verlo**

NOTA: Explica las preguntas en las que contestó SI de la B-D NO en la E.

A. ¿Ha Usted tenido alguna reacción alérgica a algún tratamiento dental en el pasado? **Sí** **No**

B. ¿Se encuentra usted en este momento bajo los cuidados de un médico? **Sí** **No**

C. ¿Ha estado usted hospitalizado o en emergencia en los últimos 2 años? Fecha ______ **Sí** **No**

D. ¿Está usted tomando algún medicamento? Por favor escriba **Sí** **No**

E. ¿Se encuentra Usted en buena salud física? **Sí** **No**

F. ¿Si eres mujer, se encuentra usted embarazada? Trimestre 1 2 3 **Sí** **No**

Información adicional ____

Consiento que ___________________________________, localizado en ___________, los operadores y cualquier dentista o trabajador de la salud de la Unidad Dental de la Convención Bautista de Florida, me examine o trate y que use y revele mi información de salud para el diagnóstico, tratamiento o alguna otra forma de cuidado incluyendo cualquier información recibida por otros clínicas médicas. Este aviso estará en vigor durante un año desde la fecha de su firma. Entiendo que este consentimiento puede ser retirado.

Reconozco lo anterior y recibo la Notificación de Derechos de Privacidad. Declare que la información medical arriba es correcta

____________________________ ____________________________ _______

Firma del Paciente/ o Guardián Firma del Voluntario Dental Fecha

CLINIQUE DENTAIRE DOSSIER MÉDICAL
FLORIDA BAPTIST CONVENTION - CHURCH AND COMMUNITY MINISTRIES

BP _____/_____ Pouls: ______ **BP _____/_____ Pouls: ______**

Nom:____ Laj:________ Dat Nesans:______________

A. Avez-vous (le patient) ou avez eu l'une des suivantes: OUI NON

	OUI	NON
À l'asthme Apportez votre inhalateur avec vous		
Diabète Type 1 ( ) insulinodépendant ou de Type 2 ( ) Mangez repas normal avant la nomination		
Épilepsie * Date de dernière crise ?		
Maladie Cardiaque : Crise Cardiaque, Accident Vasculaire Cérébral, Douleurs Thoraciques * Le remplacement valvulaire, défaut de vanne ou cœur défaut Rhumatisme articulaire aigu comme un enfant ou diagnostiqué avec un souffle cardiaque		
*** Anticoagulants** (aspirine -à-dire, Coumadin, Plavix, etc.)		
Stimulateur cardiaque		
Maladie rénale ou hépatique * (clairance de Docteur nécessaire si vous êtes sous *dialyse rénale).		
Pénicilline ou d'autres réactions indésirables aux médicaments		
Saignement prolongé après une chirurgie ou extractions dentaires		
Tuberculose Date: ____________________________________		
Maladie sexuellement transmissible, l'herpès		
Tansyon wo		
L'hépatite infectieuse (A, B, ou C)		
Articulations artificielles (à savoir la hanche, du genou, du coude		
VIH positif, ARC (complexe apparenté au SIDA)**, ou un diagnostic de sida**		
Allergies: S'il vous plaît, la liste : (latex ?)		
Kansè * Actuellement sur la chimio ou la radiothérapie		
Fosamax ou de médicaments pour l'ostéoporose / ostéopénie		
Autre fournisseur de l'information pertinente doit être conscient :		

****Si vous avez un de ces problèmes de santé, vous devez avoir la permission d'un médecin par écrit à être vu par un fournisseur sur la clinique dentaire mobile.**

REMARQUE : Expliquer les questions coché Oui dans B-D et de NO dans E.

A. Avez-vous déjà ressenti une réaction défavorable du traitement dentaire précédente ? **OUI NON**

B. Etes-vous actuellement sous les soins d'un médecin ? **OUI NON**

C. Avez-vous été hospitalisé ou dans la salle d'urgence dans les 2 dernières années ? Date: _____ **OUI NON**

D. Pensez-vous des médicaments? S'il vous plaît la liste. **OUI NON**

E. Êtes-vous actuellement en bonne santé? **OUI NON**

F. Si femelle, êtes-vous enceinte? Trimestre 1 2 3 **OUI NON**

Remarques supplémentaires: ____

Je consens à la____________________________________, situé dans_______________, les opérateurs Floride Baptiste Unité Convention mobile dentaire et tout dentiste ou professionnel de la santé ou un agent autorisé, en examinant ou me traiter d'utiliser ou de divulguer mes informations de santé protégées pour le diagnostic et le traitement ou les opérations de soins de santé, y compris les informations reçues d'autres fournisseurs de soins de santé. Cet avis sera en vigueur pendant un an à compter de date de la signature.

Je reconnais ce qui précède et de la réception de l'avis de droits à la confidentialité. Je déclare que les renseignements médicaux ci-dessus sont exactes.

______________________________	______________________________	_______________
Signature du patient ou du tuteur	**Signature du projet bénévole dentaire**	***Date***

Health Issues Authorization Form

During your medical assessment for receiving dental care, it was revealed that you have one of the following health issues listed below. To receive dental care, one must have a doctor's permission in writing to be seen by a provider on the Mobile Dental Clinic.

*SERVICE CANNOT BE PROVIDED WITHOUT COMPLETION OF THIS FORM

Health Issues

Check the ONE that applies to you:

____ Blood Thinners (i.e. Aspirin, Coumadin, Plavix, Xarelto, Pradaxa, Eliquis, other: ________________

____ Valve replacement, valve defect, heart defect

____ Artificial joint (i.e. hip, knee, elbow, other: ___________________

____ Pregnancy

____ Cancer: Currently on Chemotherapy or Radiation

Physician Authorization

Please complete the following health issue that applies to your patient:

Pregnancy/Cancer: May/May Not receive treatment from Mobile Dental Clinic.

Blood Thinners: Stop taking ______________________ (medication) / ____ (days) prior to dental appointment.

Artificial Joint: Take _________________ (medication) ___________ (dosage) ________ (time) prior to appointment time.

Patient's Name: ____

Physicians Signature: ____

Physician's Printed Name:____ Date: _____________

<u>Formulario de autorización de temas de salud</u>

Durante su evaluación médica para recibir atención dental, fue revelado que tenga uno de los siguientes problemas de salud enumerados a continuación. Para recibir cuidado dental, uno debe tener permiso de un médico por escrito para ser visto por un proveedor en la Clínica Dental Móvil.

*** SERVICIO NO PUEDE PRESTARSE SIN LA CUMPLIMENTACIÓN DEL PRESENTE FORMULARIO**

Problemas de salud

Comprobar que se aplica a usted:

____ Diluyentes de la sangre (i.e. Aspirina, Aspirina de niños, Comodín, Plavix, Xarelto, Pradaxa, Eliquis, otros:__________

____ El reemplazo de la válvula, válvula defecto, defecto del corazón

____ Empalme artificial (i.e. cadera, rodilla, codo, otros): ___________________

____ Embarazo

____ Cáncer: actualmente en quimioterapia/radiación

____ Epilepsia

____ Diálisis - Riñón

<u>Autorización del médico</u>

Por favor complete el siguiente problema de salud que se aplica a su paciente:

Embarazo, cáncer: Puede/No Puede recibir tratamiento de Clínica Dental móvil.

Anticoagulantes: Deje de tomar el ______________________/ ____ antes de la cita con el dentista.
medicación dias

Articulación artificial: Tomar _________________ ___________ ________ antes de la hora de la cita.
medicación dosificación tiempo

Recomendaciones o comentarios médicos: ____

____

____

Nombre del paciente: _____________________________________

Firma de los médicos: ______________________________________ Fecha: ______

Formulaire d'Autorisation des Soins de Santé

Au cours de votre examen médical pour recevoir des soins dentaires, il a été révélé que vous avez l'un des problèmes de santé suivants. Pour recevoir des soins dentaires, il faut avoir l'autorisation a l'écrite d'un médecin avant d'être vu par un fournisseur de la Clinique Dentaire Mobile.

*** SERVICE NE PEUT PAS ÊTRE FOURNI SANS REMPLIR CE FORMULAIRE**

Questions de Santé

Vérifier celle qui s'applique à vous :

____ Anticoagulants (i.e. Aspirin, Baby Aspirin, Coumadin, Plavix, Xarelto, Pradaxa, Eliquis, other: __________

____ un remplacement valvulaire, défaut de soupape, défaut de cœur

____ articulation artificielle (p. ex., hanche, genou, coude, autres: ___________________

____ Grossesse

____ Cancer: actuellement en chimiothérapie/radiothérapie

____ Epilepsie

____ Kidney Dialysés

Autorisation du Médecin

Veuillez remplir le problème de santé ci-dessous qui s'applique à votre patient :

Grossesse/Cancer: Peut / Ne Peut pas recevoir de traitement de la Clinique Dentaire Mobile.

Anticoagulants: Cessez de prendre le ______________________/ ____ avant le rendez-vous dentaire.
Médicaments Jours

L'articulation artificielle: Prendre _________________ ___________ ________ avant l'heure du rendez-vous.
Médicaments Dosage temps

Physiciens Comment or Recommandation: ____

____

____

Nom du patient: _________________________ Signature du Médecin: _________________ Date: ______

Request a restriction on certain uses and disclosures of your protected health information. You have the right to ask for restrictions on the ways we use and disclose your health information for treatment and health care operation purposes. You may also request that we limit our disclosures to persons assisting in your care. We will consider your request, but we are not required to accept it.

Be assured that your information will be kept confidential. The volunteers of the Baptist Association or church may call or mail you a reminder of your dental appointment. When this is done, we will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing.

Request an amendment of your protected health information. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

Receive an accounting of disclosures: You have the right to receive a list of certain instances when we have used or disclosed your dental/medical information. Your request must specify the time period, but may not be longer than six years. The first accounting your request will be provided free of charge. But you may be charged for the cost of providing any additional accountings.

Effective Date

This Notice of Privacy Practices is effective beginning March 15, 2004 and shall be in effect until a new Notice of Privacy Practices is approved and posted.

Florida Baptist Convention

____

(Name of Church or Association)

Notice of Privacy Practices

This notice describes how dental information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

We understand that your dental information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper records about your dental health, our care for you, and the services we provide to you as our patient. We have made the required changes to our procedures in order to comply fully with the **Health Information Portability and Accountability Act (HIPAA)** that was passed into law in 1996. This law sets federal standards to secure your health care information.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy ("Notice") about our privacy practices and your rights concerning your health information. This Notice describes how we may use and disclose your Protected Health Information ("PHI") to carry out treatment, health care operations and other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to our records about you.

This notice describes who will follow this notice:

- Any health care professional authorized to enter information into your chart, our mobile dental coordinators, the 110 volunteers with the Department of Health, and the Baptist association or church volunteers authorized to take your medical history.
- Our office personnel, dentists/dental assistants, physicians or pharmacists who may call the host site concerning a prescription.

In addition, these individuals may share dental/mental information with each other for treatment purposes described in this notice. We will gather dental/medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are a part of your circle of dentists, physicians and family members.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

Treatment: We may use or disclose your health information to a dentist, our mobile dental professionals or other health care providers providing treatment to you.

Dental Operations: We may use and disclose your medical/dental information among those directing the dental project to assure that all your information is properly recorded in your file.

Appointment Reminder: We may use and disclose medical information to contact you as a reminder that you have an appointment for dental care.

Your Authorization: In addition to our use of your health information for treatment, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Required by Law: We will disclose medical information about you when required to do so by federal, state, or local law.

Communication With Individuals Involved In Your Care:
We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical/financial information about you in response to a court or administrative order. This is particularly true if you make the treatment you received on our dental unit an issue. We may also use such information to defend ourselves in any actual or threatened action.

Patient Rights

You have the following rights regarding the protected health information that we maintain about you:

Obtain a paper copy of the Notice upon request. You may request a copy of the Notice at any time. To obtain a copy, contact the church or association who sponsored the mobile dental clinic in your area.

Demandas y quejas: Si usted ha encausado un juicio, podemos revelar información médica/financiera sobre usted para contestar alguna citación judicial o una orden administativa. Y estaremos aún más interesados en eso si su queja se concentra en el tratamiento que usted recibió en nuestra clínica dental móvil. También podemos utilizar tal información para defendernos en caso de que haya un pleito o demanda entablado contra nosotros.

Derechos del Paciente

Usted tiene los derechos siguientes en cuanto a la informacion médica protegida que mantendremos sobre usted.

Usted tiene derecho a obtener una copia impresa del Aviso sobre Normas de Privacidad por petición escrita. Usted tiene derecho a solicitar una copia del Aviso cuando quiera. Para recibir una copia póngase en contacto con la iglesia o asociación que auspició la clínica dental móvil en su región.

Usted tiene derecho a solicitar que se restrinja el uso y divulgación de su información médica protegida. Usted puede pedir restricciones sobre la divulgación de su información de la salud que usaremos para realizar cualquier tratamiento o actividades de atención médica. También puede limitar la divulgación a individuos que intervienen en su atención. Consideraremos su petición, pero no tenemos la obligación de aceptar ninguna restricción.

Usted tiene derecho a que se le asegure que su información se mantendrá confidencial. **Los voluntarios de la Asociacion Bautista o iglesia pueden escribirle o llamarle para recordarle las citas para su atención dental. Si se realiza eso, nos pondremos en contacto con usted de la manera que usted decida y a la dirección o número telefónico que usted seleccione. Es posible que se le pida que envíe la solicitud por escrito.**

Usted tiene derecho a pedir una enmienda a su información de la salud protegida. Si usted cree que la información en su expediente es inexacta o incompleta, usted tiene derecho a que la información se corrija o que se añada cualquier información perdida del expediente. Es possible, en algunas circunstancias, que su petición se le deniegue si por ejemplo, se encuentra que la información es exacta y completa.

Usted tiene derecho a recibir un resumen de ciertas circunstancias en que su información médica protegida se haya divulgado. Usted puede pedir una lista de ciertas circunstancias en que podamos haber utilizado o divulgado su información medica/dental protegida. Su petición debe especificar el período, pero no más de seis años a partir de la fecha de su solicitud. Se le proporcionará gratuitamente, el primer resumen que pide, pero usted debe ser responsable por el costo de otros resúmenes adicionales.

Fecha de vigencia:

Este Aviso sobre Normas de Privacidad tiene vigencia a partir del 15 de marzo del 2004, y regirá hasta que se apruebe y publique un nuevo Aviso sobre Normas de Privacidad.

Convención Bautista de Florida

____
(Nombre de la iglesia o asociación)

Aviso sobre Normas de Privacidad

Este aviso describe la forma en que se puede usar y divulgar su información dental y la manera en que usted puede tener acceso a la misma.

Por Favor Lea Atentamente

Sabemos que su información dental es personal, y nosotros estamos comprometidos a proteger esa información. Como paciente nuestro, creamos documentos por escrito, como la historia clínica sobre su salud dental, el cuidado que le hemos dado y los servicios que le proporcionamos . Hemos realizado los cambios requeridos de nuestros procedimientos para cumplir por completo con el **ACTA DE LA PORTABILIDAD Y RESPONSABILIDAD DE INFORMACION DE SALUD (APRIS)** que se firmó como ley en 1996. Esta ley establece las normas federales que aseguran su informacion de cuidado de salud.

De acuerdo a las leyes federales y estatales pertinentes tenemos la obligación de mantener la privacidad de la información de su salud protegida. También, como parte de los deberes jurídicos del Departamento de Salud, se le debe entregar este Aviso sobre Normas de Privacidad que explica nuestro reglamento de privacidad y sus derechos con respecto a su información de salud protegida. Este Aviso describe de que modo se puede usar y divulgar su Informacion de Salud Protegida (ISP) para llevar a cabo tratamientos, actividades de atención de la salud y otras razones específicas permitidas y requeridas por la ley. El Aviso también describe sus derechos en cuanto al expediente que mantenemos sobre nuestra atención clínica a usted.

Este aviso explica cómo y por quien se puede ser usada su información médica protegida:

- Cualquier profesional de la salud autorizado para anotar información en su expediente, nuestros coordinadores de la clínica dental móvil, los voluntarios 110 con el Departamento de Salud y los voluntarios de la Asociación Bautista o de la iglesia autorizados para llenar su historia médica.
- Nuestra secretaria, los dentistas o asistentes de dentista, los médicos o farmacéuticos que puedan llamar al sitio auspiciador con respecto a una receta.

Además estos profesionales de la salud pueden compartir información médica/dental entre ellos con fines de tratamientos como se ha destacado en este aviso. Compilaremos información medica/dental de usted y crearemos un expediente que contendrá la atención médica proporcionada a usted. También se puede compartir cierta información con nosotros por individuos u organizaciones que forman parte de su círculo de dentistas, médicos y familiares.

Formas Que Podemos Utilizar y Divulgar

La información médica protegida sobre usted

Tratamiento: Podemos usar o divulgar su infomación de salud a un dentista, los profesionales de nuestra clínica dental móvil o a otros profesionales de la salud que le estén atendiendo a usted.

Proyectos Dentales: Podemos utilizar y revelar su información protegida médica/dental entre todos los que estén involucrados con el proyecto dental para asegurar que todos los datos de su información se documenten corectamente en su expediente.

Recordatorios de citas: Podemos usar y divulgar información médica para recordarle que tiene una cita para recibir atención dental.

Su autorización: Además de nuestro uso de su información de la salud con fines de tratamiento, usted puede darnos su autorización por escrito que nos permitirá utilizar o divulgar su información médica protegida a cualquier persona o por cualquier razón. Si usted nos da una autorización, la misma se puede revocar por escrito en cualquier momento. Su revocación no afectará el uso de las divulgaciones permitidas por su autorización si el uso sucedió cuando estaba en efecto la autorizacion. Para otros usos y divulgaciones de su información médica protegida se requerirá su autorización por escrito.

Para familiares y amigos: Tenemos la obligación de revelar su información de la salud a usted, como se describe en la sección titulada 'Derechos de paciente' en este Aviso. También podemos divulgar su información médica protegida a alguien que sea familiar, amigo, u otro designado por usted como se necesite para ayudarle a conseguir atención médica, pero solamente si usted nos permite a hacerlo.

Deberes jurídicos: Revelaremos información médica sobre usted cuando sea requerido por la ley federal, estatal, o local.

Comunicación con individuos involucrados con su atención dental:

Podemos utilizar o divulgar información de la salud para notificar o ayudar con la notificación (incluyendo la identificación o la búsqueda) a un familiar, a su representante personal, o a otro que sea responsable de su atención, su condición general, o su muerte. Si usted esta presente, entonces previo al uso o a la revelacion de su informacion de la sauld, le daremos una oportunidad para objetar tales usos o declaraciones. En caso de incapacidad o circunstancias de emergencia, divulgaremos su información de la salud por medio de una determinación basada en nuestra experiencia como profesionales y también revelaremos solamente la información que sea directamente pertinente a la participación de la persona en su atención médica.

Kom nap kite tout enfòmasyon ou yo konfidansyel. Pou moun kap ede ou yo tankou Baptist asosyasyon ou, ou legalize met rele ou, ou voye yon lèt pou fè ou konen ou gen yon randevou (appointement) pou wè dantis. Lè nap kontakte ou nan pe bon adrès ou genyen ou rele ou nan telefòn ou vle. Petet nap mande ou mete sa sou papye.

Pou mande yon amandman sou enfòmasyon ki kon. Sène ou nan zafè medikal pa vre ou byen si ou pa gen tout enfòmasyon pou nou fè li vrè e konplete li. Gen kek fwa nou pap fè sa pou si nou jite tout enfòmasyon ou korèk e konplè.

Pou jwenn sak pase avèc enfòmasyon nap bay sou ou yo. Ou kapab gen yon lis ki di lè nou sèvi ak enfòmasyon medikal ki regade ou bé ou mande sa, fòk ou mande pou kon-byen tan ou vle enfòmasyon sa, ou kap mande pi plis (6) sis zan. Si óu vle li pou plis tan ou beswen peye pou li.

Dat Efektive: Notis sa Prive Practice apati 15 Mas 2004 jis yon lòt Notis Practice Prive ekri e adopte.

Florida Baptist Convansyon

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(Non de Legliz ou Asosyasyon)

Notice de Practice Privi

Papye sa a eksplike ki enfomasyon ou ka jwenn nan papye sa sitou sou sak regarde sante pou dan.

Nou mande ou tanpri souple pran yon ti tan pou lil byen.

Nou vle ou konprann trè byen enpotans dan nan bouch se poutèt sa nap ede pran swen bouch epi kenbe tout enformasyon sou sante ou an sekré mem jan ak tout lot pasyan ki vin nan you klinik Medikal. Nou vle ou konnen tout anfòm syon avek **"Health Enformasyon Potrability and Accountability Act" (HIPAA)** Se une lwa federal te pase 1996 pwoteje yout enformasyon prive. "Federal Standards" Leta Federal di nou lwa sa pou kenbe tout sekré vi prive yon pasyan genyen. Nous bezwen konnen dwa nou nan sak gade zafe lasante, fè operasyon ak lot bagay nou ka fé sou lavi sa. "HIPAA"

Notice sa di ou ki dwa ou geyen lè yo pale ou mete nan lari eta sante ou nan laye.

- Tout persoèl swen sante ki gen otorizasyon ka mete tout enformasyon nan "dosye ou". Tout mobil dantal geyen 110 volontè avek departman sante asosyasyon Baptist Medikale volontè, avek legliz ki pemisyon pou pran istwa medical yon pasyon.
- Tout moun ki nan ofis la ki ede dantis la, Docté, Famasyen ka rele "host site" pou yon preskripsyon..

Anplis, moun sa met di dantis/medsen tout enformasyon pou yo ka ede, jan nou ted deja di ou la. Nap jwen yon rapò ki di ou sa nap fè pou ou, ak sa dantis la ak medsen an ap fe pou ou. Nap gen enfòmasyon lót moun ou òganizasyon ki asire dantis ou we, Doctè ou, fammi ou.

SA NAP FE AK ENFÒMASYON MEDIKAL KI GEN AK OU.

Na pati sa nap di kèk chwa, fè pou sevi byen ak enfòmasyon medikal nou genyen yo. Epi lot moun ki bezwen enfòmasyon sa. Genyen kek fwa lè n sèvi ak enfòmasyon ki pa nan lis sa. Ekspliasyon nou ba ou se pou enfòmasyon pa ou.

Tretman: Nou kapab sevi byen avek enfòmasyon medikal ki regade pèsonelman, yon dantis ou, ekip mobil dantis la, ou byen lot moun ki nan gwoup medikal ki vle ede ou.

Operasyon Dan: Nou kapab sevi ou byen epi ba ou bon jan enfòmasyon medikal nan sa ki konséne ou, ak tout moun kap dirye pwojè dental la e nou asire ou pou tout enfòmasyon ak record pa ou.

Pou ou ka konnen ke lé dat randevou (appointement) ou yo: Nan tout ki konsène randevou medical/dental nap kenbe ou okouran nap rele ou pou pa bliye vin we dantis ou.

Otorizasyon deyò: Nou ajoute di nou eske nou met fè sa nou vle avek enfòmasyon ou yo pou tretman, se pou nou met ba mou otorizasyon nan yon papye ekri, fé sa vle avek enfòmasyon medikal mwen yo pou nenpòt ki rezon sa pap afekte ni li pa dwe afecte ou. Si ou pa ba nou yon otorazasyon ekri, nou kapab sèvi ak enfòmasyon ou yo pou selman ki nan notis sa.

Pour Fanmi e Zanmi: Nou bezwen bay enfòmasyon medikal ki soti nan menou jan nou te eksplike sa "Dwa Pasyan Yo" section de notice sa. Nou kapab bay enfòmasyon sou sa ki regarde ou a yon zanmi, yon manb fanmi ou, ak yon lot moun lè sa mesesè ou ede ak pwoblèm medikal ou genyen si di nou ka fè sa.

Sa lalwa di: Nan bay enfòmasyon medikal ki regade yon pasyon lè ou bezwen paske leta Federal, obyen lalwa kou yo bezwen.

Ko mi ni kasyon ak moun kap ede pou jwenn bon sevis: Nou ka sevi nan ba ou bon jan enfòmasyon medikal kap itil ou, asiste ou nan li enfòmasyon notifikasyon yon ki nan fanmi ou, yon ki reprizante ou, yon moun ki responsab ou pou lavi ou ou byen ou mouri. Si ou la nap bay ou yon chwa pou ou di ou pa vle sevi ou byen bay enfòmasyon medikal. Si ou gen you yans e ou paka pale, nap bay enfòmasyon medical yo doctè bezwen ki revele pou moun kap ede sou rezon medikal.

Despit ak Kay Avoka: Se gen dispit ak kay avoka nou kapab bay medical/finans ki gen rapò ak ou la na responn nan tribunal, ou lòd administativ. Sa se vre si ou di tretman ou jwenn nan inite dental pa nou se yon pwoblem. Nou kab sevi ak enfòmasyon sa pou pwoteje nou si gen yon problem.

Dwa Pasyan Yo

Ou gen dwa pou li enfòmasyon medikal ki pwoteje ou kou nou genyen yo:

Ou gen dwa yon kopi sou papye notis ou si ou mande li. Ou ka mande kopi notis la nenpot lè ou vle li pou jwenn yon kopi rele legliz, ou asosyasyon ki te genyen mobil klinik dental la, la ba ou yon kopi.

Mande restriksyon sou sèten sèvis nou genyen pou bay enfòmasyon medikal na ki kosene ou. Sou ki jan nou ede e medikal operssyon. Ou met mande pou nou pa bay enfòmasyon. selman nan moun kap ede ou. Nap panse sou sa ou mande a, men nou gen dwa pa aksepte li.

MOBILE DENTAL UNIT

Project Location: ______________________________________Date: _______________________

Association: ____Number of Patients: ___________

VOLUNTEER SIGN-IN SHEET

Name	Dentists, Dental Assistants, DOH 110 Volunteers, Volunteers	Time In	Time Out	Total Hours

POST SURGERY INSTRUCTIONS

1. Following an extraction hold a gauze in the mouth for at least 30-45 minutes firmly, then remove. If bleeding persists, place more gauze and bite firmly another 10 minutes. Repeat if necessary, or replace gauze.

2. If bleeding continues after 2 hours, place a moistened tea bag over the area and bite firmly for 10 minutes. Avoid hot liquids during this time. If you continue to have a problem, call the referral dentist or the church.

3. DO NOT RINSE YOUR MOUTH FOR AT LEAST 24 HOURS AFTER EXTRACTION. After 24 hours you may rinse GENTLY 3 or 4 times a day for the next 3 to 4 days using a warm salt solution consisting of 1 teaspoon of salt dissolved in a glass of water. Always rinse thoroughly after eating.

4. DO NOT DRINK THROUGH A STRAW for 24 hours, or smoke, or spit, or rinse your mouth out (FOR AT LEAST 3 DAYS AFTER EXTRACTION). This could dislodge the clot forming in the hole where the extraction was done. This is know as a "DRY SOCKET" and is very painful.

5. Do Not Drink bubbly substances, such as soda, or acidic liquids such as Orange juice for the First 24 hours.

6. Swelling after an extraction is not uncommon and need not cause alarm. However, to control this, apply an ice bag or towel saturated in ice water against the cheek for 15 minutes. Repeat ½ hour later.

   If swelling has already occurred, apply a cold towel or cold water bag against your cheek for 15 minutes. Repeat ½ hour later as needed until swelling leaves.

7. If pain is persistent after the feeling is back in your mouth, you can take any over-the-counter medication such as Tylenol (Acetaminophen) or Advil (Ibuprofen). Lie down and try to relax. If you continue to have a problem, call the referral dentist or the church.

8. After the anesthesia wears off, you may eat. Soft foods are advisable during the first 24 hours.

INSTRUCCIONES PARA DESPUES DE LA CIRUGIA

1. Después de una extracción mantenga una gaza en la boca por lo menos 30-45 minutos con firmeza, y luego retírela. Si la hemorragia persiste, ponga más gaza y muerda con firmeza otros 30 minutos. Repita si es necesario, o sustituir la gaza.

2. Si el sangrado continúa después de dos horas, coloque una bolsa de té húmeda sobre el área y muerda firmemente durante 10 minutos. Evite los líquidos calientes durante este tiempo. Si usted continúa teniendo problema, llame al dentista de la referencia o la oficina local de la Asociación Bautista.

3. No se enjuague la boca por lo menos 24 horas después de la extracción. Después de 24 horas usted puede enjuagarse cuidadosamente 3 o 4 veces al día por los próximos 3 días usando una solución salina que consista de 1 cucharadita de sal disuelta en un vaso de agua tibia. Siempre enjuáguese bien después de comer.

4. No beber con un popote por 24 horas, fumar, escupir, ni enjuagarse la boca (por lo menos 3 días después de la extracción). Esto podría desalojar el coágulo que se forma en el espacio/área donde se realizó la extracción y es muy doloroso.

5. No consuma sustancias burbujeantes, como soda, o líquidos ácidos, como jugo de naranja, por los primeros 24 horas.

6. Inflamación después de una extracción es común y no tiene por qué causarle alarma. Para controlar la inflamación, aplique una bolsa de hielo o una toalla saturada en agua con hielo contra la mejilla durante 15 minutos. Repita media hora más tarde.

   Si la hinchazón ya se ha producido, aplique una toalla fría o una bolsa de agua fría contra la mejilla durante 15 minutos. Repita media hora más tarde como sea necesario hasta que baje la inflamación.

7. Si el dolor es persistente después de que la sensación está de vuelta en su boca, usted puede tomar cualquier medicamento como Tylenol (Acetaminophen) o Advil (Ibuprofen) que no necesitan receta médica. Acuéstese y trate de relajarse. Si usted continúa teniendo problemas, llame al dentista de la referencia o la oficina local de la Asociación Bautista.

8. Después que pase el efecto de la anestesia, puede comer. Se aconseja alimentos blandos durante las primeras 24 horas.

INSTURCTIONS A SUIVRE
APRES UNE CHIRURGIE DENTAIRE

1. Après une gaze de prise d'extraction dans la bouche pendant au moins 30-45 minutes fermement, enlevez alors. Si le saignement persiste, placez plus de gaze et de morsure fermement encore 10 minutes. Répétez au besoin, ou remplacez la gaze

2. Si le saignement continue après deux heures, placez un sachet a the humide sur l'endroit et mordez fermement pendant 10 minutes. Evitez des liquides chauds durant ce temps. Si vous continuez a experimenter des problemes, appelez le dentiste de reference ou l'office de l'association Baptiste locale.

3. Ne vous rincez pas la bouche pendant au moins 24 heures après une extraction. Apres 24 heures vous pouvez rincer légèrement 3 ou 4 fois par jour au cours des 3 à 4 jours qui suivent usant de la solution de sel chaud consistant en une cuiller à thé de sel dissout dans un verre d'eau. Rincez complètement après un repas.

4. NE BUVEZ PAS PAR UNE PAILLE pendant 24 heures, ou fumée, ou broche, ou rincez votre bouche dehors (PENDANT AU MOINS 3 JOURS APRÈS EXTRACTION). Ceci pourrait déloger le caillot formant dans le trou où l'extraction a été faite. C'est savent comme « DOUILLE SÈCHE » et sont très douloureux

5. Ne buvez pas les substances pétillantes, telles que la soude, ou les liquides acides tels que le jus d'orange

6. L'enflure après une extracion, est très commune. Par conséquent, elle ne doit alarmer personne. Cependant, pour la contrôller, appliquez un sachet de glace ou une serviette satureé d'eau glaceé contre le menton pendant 15 minutes. Repétéz ½ heure plus tard.

   Si l'enflure s'est déjà produite appliquez une serviette d'eau froide ou un sachet d'eau froide contre le menton pour 15 minutes. Répétez ½ heure plus tard au besoin jusqu'à la disparition de l'enflure.

7. Si la douleur persiste après que la sensation retourne à votre bouche, vous pouvez prendre n'importe quel médicament au comptoir de vente tel que Tylenol ou Advil. Couchez-vous et essayez de vous deténdre. Si vous continuez à voir un problème, appelez le dentiste de référence ou l'office de l'Association Baptiste locale.

8. Après que l'anesthésie porte au loin, vous pouvez manger. Des aliments légers sont recommendés durant les premières 24 heures.

(French)

Appointment Card

Give the appointment card and the dental clinic medical form to the person at the time of screening.

Appointment Card

________________________________ has an appointment to see a dentist on
Name

___________________ at _______________ AM PM
Date *Time*

at __________________. **This is a *free* visit.**
Location

Sponsored by _____________________________________
Name of Association or Church

Appointment Card

________________________________ has an appointment to see a dentist on
Name

___________________ at _______________ AM PM
Date *Time*

at __________________. **This is a *free* visit.**
Location

Sponsored by _____________________________________
Name of Association or Church

Additional Treatment Needed

Additional Treatment Needed

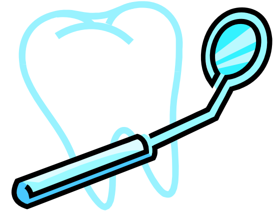
Patient's Name: ______________________________ Date: ____________________________

Dear Parent,

Your child needs some additional dental care. Please contact your dentist for an appointment.

____
Dentist

Comments: ____
____
____



Additional Treatment Needed

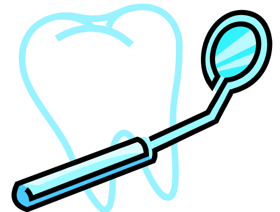
Patient's Name: ______________________________ Date: ____________________________

Dear Parent,

Your child needs some additional dental care. Please contact your dentist for an appointment.

____
Dentist

Comments: ____
____
____



Modelo

Entregue la tarjeta Y la planilla de la clinica dental a la persona en el momento del examen.

Tarjeta Para El Cita

______________________________ tiene un cita para ver al dentista el
Nombre

________________ a las _____________ AM
fecha *hora* PM

en ______________. **Esta es una vista *Gratis*.**
lugar

Patrocinada por _________________________________
Nombre de la asociación

Tarjeta Para El Cita

______________________________ tiene un cita para ver al dentista el
Nombre

________________ a las _____________ AM
fecha *hora* PM

en ______________. **Esta es una vista *Gratis*.**
lugar

Patrocinada por _________________________________
Nombre de la asociación

Modelo de la Planilla Para Tratamiento Adicional

Modelo de la Planilla para Tratamiento Adicional

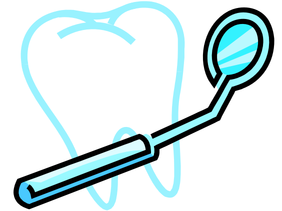
Nombre del paciente: ______________________ Fecha: _______________

Estimado Padre:

Su hijo necesita tratamiento dental adicional. Tenga la bondad de comunicarse con su dentista.

____
Dentista

Comments: ____
____
____



Modelo de la Planilla para Tratamiento Adicional

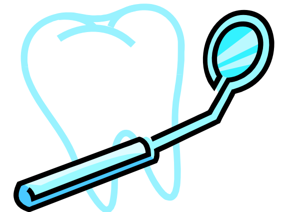
Nombre del paciente: ______________________ Fecha: _______________

Estimado Padre:

Su hijo necesita tratamiento dental adicional. Tenga la bondad de comunicarse con su dentista.

____
Dentista

Comments: ____
____
____



Spanish

Carte de Rendez-vous

Donner la carte et la formulaire dentaire us patient a remplir des la premiere visite.

Carte de Rendez-vous

________________________________ A un rendez-vous chez le dentiste
Nom

____________________ a ________________ AM PM
date *time*

a______________________________.
lieu

Cette consultation vous est offerte *gratuitement de la part de l'association*.

Suivante: ____
Nom de l'association

Patrocinada por ____________________________________
Nombre de la asociación

Carte de Rendez-vous

________________________________ A un rendez-vous chez le dentiste
Nom

____________________ a ________________ AM PM
date *time*

a______________________________.
lieu

Cette consultation vous est offerte *gratuitement de la part de l'association*.

Suivante: ____
Nom de l'association

Dentaires Suplementaires

Dentaires Suplementaires

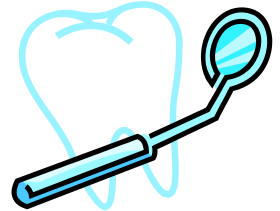
Nom de patient: ______________________________ le: ________________
date

Cher parent,

Votre enfant a besoin de soins dentaires suplementaires. Veuillez contracter votre dentiste pour un nouveau rendez-vous.

____
Nom du dentiste

Comments: ____
____
____



Dentaires Suplementaires

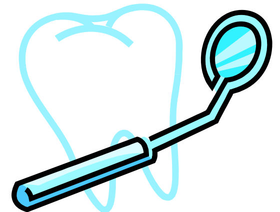
Nom de patient: ______________________________ le: ________________
date

Cher parent,

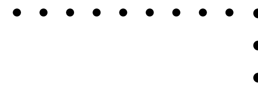
Votre enfant a besoin de soins dentaires suplementaires. Veuillez contracter votre dentiste pour un nouveau rendez-vous.

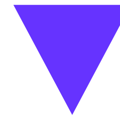
____
Nom du dentiste

Comments: ____
____
____



Community Ministries
Florida Baptist Convention
6850 Belfort Oaks PL
Jacksonville, FL 32216
800.226.8584, extension 3133





Forms to Use After the Project

- Clinic Operation Summary Report*
- Evaluation of Project*

**Please make a copy of these forms for your records and return the originals to the Community Ministries Team*

Dental Project Summary Report

Email to: Marc.Johnston@flbaptist.org

Church / Association: Date: ______________________

1. Number of Patients: ________

   Adults: _______ Children:_______

2. Number of Volunteer Dentists:_______ Total Hours Volunteered:_______

3. Number of Dental Assistants:_______ Total Hours Volunteered: _______

4. Number of Other Volunteers:_______ Total Hours Volunteered: _______

5. Total Hours of Clinic Operation: _______

6. Total Value of Services Offered: $_______

7. Number of Fillings _______

   Number of Extractions _______

8. Number of Referrals to Outside Sources: _______

9. Number of Evangelistic Encounters______

10. Number of Professions of Faith: _______

11. Number of Other Decisions: _______

Evaluation of Mobile Dental Project

Email to: Marc.Johnston@flbaptist.org

Church / Association: ________________________________ Date of Project: _______________

1. Did the planning manual offer you the help you needed in planning this project?
   ❑ Yes ❑ No
2. Do you feel there was enough communication and help from the Church and Community Ministries Team at the Florida Baptist Convention? ❑ Yes ❑ No
3. What do you feel was accomplished through your project? ____________________________
   ____
   ____
   ____
4. What can be done locally to improve this type of project in the future? How can the Church and Community Ministries Team assist you in improving the project? ___________________
   ____
   ____
   ____
5. How would you evaluate the ministry of the mobile dental coordinators? _______________
   ____
   ____
   ____
6. Did your volunteers have witnessing opportunities? ❑ Yes ❑ No
   If not, in what ways can you meet spiritual needs next year? _________________________
   ____
   ____
   ____
   ____
7. Were dental or health kits given out to your patients? ❑ Yes ❑ No
8. Additional Comments: ____
   ____
   ____
   ____
   ____

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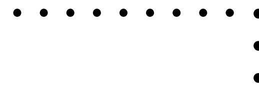

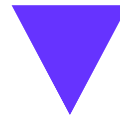

Resources

- Certificate of Volunteer Service for Dentists
- Certificate of Volunteer Service for Dental Assistants
- Volunteer Health Services Program Staff Directory

Letter to Patients

Florida Baptist Convention | Right Beside You.

The ***sample*** letter on the following page can be used as a witnessing tool for your patients and may be reproduced for your project. You will need to fill in the name of church or association at the bottom of the page and **copy as many as you will need** for the project

Because We Care...

Florida Baptist Convention Mobile Dental Unit

Dear Friends,

What a privilege it is for us to reach out to you in the Name of our Lord Jesus Christ and minister to your physical need. You are being treated today because there are many people that have come together to make this service available to you without charge.

The Lord says in Matthew 25:40 *"I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me."* It is our joy to bless you because the Lord has first blessed us. He has made this day possible. He has brought these dentists to you through the caring Southern Baptists that have purchased the mobile dental van. He has provided the people who staff it. He has called people to support it financially. He has allowed the Florida Baptist Convention to bring this service to your community. Why have we done this? We do it because we love the Lord Jesus Christ and want to extend His love to you.

You are not here by accident. God in His vast plan has made it possible for you to hear about this clinic. He has made an appointment slot available just of you. He desires that you know how much He loves you and that He has a wonderful plan for your life. It would be our greatest joy to share with you how you can come into a personal relationship with The Almighty God of the universe. He desires that you know Him personally so that you can experience all that He has planned for your life. In His Word He tells us, *"For I know the plans I have for you", declares the Lord, " plans to prosper you and not to harm you, plans to give you hope and a future".* Jeremiah 29:11

If you are not experiencing the life God has planned for you, please ask any of the hosts of this project for help. We would be most honored to answer your questions and help you to discover how wonderfully different life is when lived in the way that He has planned for each one of us. Please allow our personnel and volunteers to answer your questions about this God who cares for you...that is why we are here.

The Staff of the Mobile Dental Unit

CERTIFICATE of VOLUNTEER SERVICE

FOR PROJECT: DENTISTS CARE
In recognition of

____
NAME

____
FLORIDA LICENSE NUMBER

For Completion of __________ hours of pro bono dental care Of the underserved and financially needy
Number of Hours Worked

For which ______________ credits of continuing education for
One credit for one hour of work

Dental licensure in the State of Florida are hereby awarded.

At______________________ on ______________________
Name of Facility — Month Day Year

____
Project Director

____
MDU Coordinator

Florida Baptist Convention | Right Beside You.

Revised 01/10

CERTIFICATE OF
Volunteer Service

FOR PROJECT: DENTISTS CARE

In recognition of

____

Name

For completion of________________ hours of pro bono dental care of the underserved and financially needy

Number of hours Worked

At ______________________________ on ________________________

Name of Facility — Month Day Year

____

Project Director

____

MDU Coordinator

Revised 8/10

Volunteer Health Services Staff Directory

Region 1
Susan Prescott
© (850) 408-6427

Region 2
Susan Prescott
© (850) 408-6427

Region 3
Lori Thompson
(904) 209-3250 x 1134
©(904) 588-8307

Region 4
Joyce Coufal
© (352) 551-8066

Region 5
LaRaine Berkeley
(407) 858-1400 Ext. 1161
© (407) 723-5138

Region 6
Marielys Mujica-Perez
© (813) 434-5483

Region 7
Steve Krajewski
(772) 785-6183
© (772) 579-3546

Region 9
Catherine Jackson
(561) 671-4032

Region 10
Ray Nellissery
(954) 467-4700 x 5170

Region 11
Carmen Hernandez
(786) 336-1280

Christopher P. Gainous
Supervisor, Volunteer Health Services
(850) 245-4104
© (850) 728-7069

Revised 08/24/2018

VOLUNTEER HEALTH SERVICES
STAFF DIRECTORY

HEADQUARTERS

Christopher Gainous
DOH Volunteer Health Services Supervisor
4052 Bald Cypress Way, Bin # C15
Tallahassee, FL 32399-1743
Phone: (850) 245-4104, © (850)728-7069
FAX (850) 922-6296
E-mail: Christopher.Gainous@flhealth.gov

REGION 1&2 – Bay, Calhoun, Escambia, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, Washington, Franklin, Gadsden, Gulf, Jefferson, Lafayette, Leon, Liberty, Madison, Taylor, Wakulla

Susan Prescott
Florida Department of Health in Walton County
362 State HWY 83
De Funiak Springs, Fl. 32433
Phone: (850) 408-6427
E-mail: Susan.prescott@flhealth.gov

REGION 3 – Alachua, Baker, Bradford, Clay, Columbia, Duval, Flagler, Hamilton, Nassau, Putnam, St. Johns, Suwannee, Union, Volusia

Lori Thompson
Florida Department of Health in St. Johns County
200 San Sebastian View
St. Augustine, FL 32084
Phone: (904)209-3250 x 1134 © (904) 588-8307
E-mail: Lorraine.Thompson2@flhealth.gov

REGION 4 – Citrus, Dixie, Gilchrist, Lake, Levy, Hernando Hillsborough, Marion, Pasco, Pinellas, Sumter,

Joyce Coufal
Florida Department of Health in Lake County
16140 US HWY 441
Eustis, FL 32726
Phone: © (352) 551-8066
Fax (352) 589-6492
E-mail: Joyce.Coufal@flhealth.gov

REGION 5 – Orange, Seminole, Osceola

LaRaine M. Berkeley
Florida Department of Health in Orange County
6101 Lake Ellenor Drive
Orlando, Fl. 32809
Phone: (407) 723-5138 © (407) 516-7736
Fax : (407) 858-5519
E-mail: Laraine.Berkeley@flhealth.gov

REGION 6 – Charlotte, Desoto, Hardee, Manatee, Polk, Sarasota

Mariely Mujica Pérez
Florida Department of Health in Polk County
1290 Golfview Ave
Bartow, Florida 33830
Phone: © (813) 434-5483
Email: Mariely.MujicaPerez@flhealth.gov

REGION 7 – Brevard, Collier, Glades, Hendry, Highlands, Indian River, Lee, Martin, Okeechobee, St. Lucie

Steve Krajewski
Florida Department of Health in St. Lucie County
5150 NW Milner Drive
Port St. Lucie, FL 34983
Phone: (772) 785-6183, © (772) 579-3546
Fax (772) 595-1306
E-mail : Steven.Krajewski@flhealth.gov

REGION 9 – Palm Beach

Catherine Jackson
Florida Department of Health in Palm Beach County
800 Clematis Street
West Palm Beach, FL 33401
Phone: (561) 671-4032
Fax: (561) 837-5190
E-mail: Catherine.Jackson@flhealth.gov

REGION 10 - Broward

Ray Nellissery
Florida Department of Health in Broward County
780 Southwest 24th Street, Ste. 207
Fort Lauderdale, FL 33315
Phone : (954) 467-4700 Ext. 5170
E-mail : Ray.Nellissery@flhealth.gov

REGION 11 – Miami-Dade, Monroe

Carmen Hernandez
Florida Department of Health in Miami-Dade County
8323 N.W. 12 Street, Ste. 212
Miami, Florida. 33126
Phone: (786) 336-1280
Fax: (786) 336-1297
E-mail: Carmen.Hernandez3@flhealth.gov

March 18, 2018