Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

MOBILE DENTAL MINISTRY

Planning Manual

BECAUSE WE CARE...

Revised for 2023

A Cooperative Program Ministry of the Florida Baptist Convention

Table of Contents

Table of Contents

**If you need one of these forms in a Word Document please contact Loida Reyes at lreyes@flbaptist.org

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 Ministry includes the Mobile Dental Ministry Unit and the newly acquired Preventive Care Portable Delivery System. These are 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. The Mobile Dental Ministry is a major part of the Florida Baptists Convention's Community Ministries.

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 Ministry 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 Ministry will assist the local church in making disciples through the Gospel of Jesus Christ by giving special attention to their health needs.

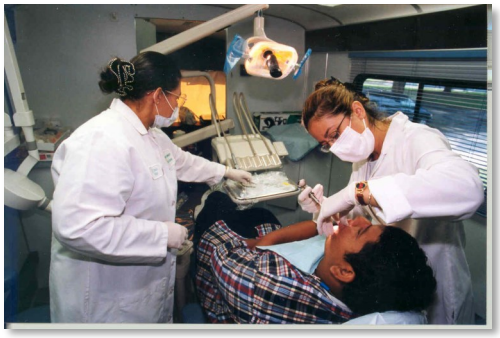
Community Ministries desires to serve with you as you reach out to your community with the gospel of Jesus Christ. We, as Florida Baptists, are a team with a great desire to make a difference in the lives of people.

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 Ministry!

Marc Johnston

Community Ministries Catalyst
Florida Baptist Convention
6850 Belfort Oaks Place
Jacksonville, FL 32216
(800) 226-8584 Ext. 3133
(904) 596-3133
(904) 571-8037 (Cell)
(904) 396-7712 (fax)



Meet our Mobile Dental Ministry Team

The Ministry Team concept has been developed in an effort to make the Mobile Dental Ministry Unit user-friendly. We want you, the Church or Association, to be able to customize a Dental Mission 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. Though each Team member has specific duties, they are experienced in all areas of planning and executing a Dental Mission and are happy to help where they can. The Team consists of:

MDMU Coordinators
Dental/Hygienist Consultants
Dental Mission Trainers
Transportation and Maintenance Engineer

The MDMU Coordinators are present with the Unit while it is in your area. They arrive, set up the equipment in the operatories, and do the duties on the Unit to keep it prepared for the dentists, dental assistants, and patients throughout your dental mission. They sterilize equipment, and sanitize the operatories between patients. They orient the dentist and the dental assistants to the X-ray equipment and instruments.

The Dental/Hygienist Consultants are licensed and practicing dentists and hygienist who have come alongside the Mobile Dental Ministry. They are available for consultation in planning your dental mission. Please note that the MDMU coordinators are **NOT** dental assistants.

Dental Mission Trainers are available to come to your church and train your Mission leadership and volunteers in how to plan and run your dental mission.

Our Transportation and Maintenance Engineer drives the Unit to your location and sets it up for operation. The Engineer keeps all equipment maintained and ready for use at your mission, as well as making sure the Unit's mechanical parts are in good repair.

Mobile Dental Ministry Team Leaders

Farrell & Crystal Crews

Farrell – Transportation & Maintenance Engineer

904-583-2046

Crystal – Lead MDMU/Purchasing Coordinator

904-868-8145

Granny1999c@aol.com

MDMU Coordinators:

Beckie Layman
386-854-0374
beckie.layman@gmail.com

Mary Nanny
321-505-2562
mgosoriog@aol.com

Diana Ohanesian
734-497-3108
Diana_ohanesian@comcast.net

Jamie Gregory
561-373-6824
jamiefirstair@gmail.com

Fred & Pam Lovelace
904 – 673-1136
40blaster@gmail.com

Dental Mission Trainers:

Mike & Lisa Smith
703-872-9965 Lisa
703-872-9964 Mike
mlslbs35@yahoo.com

Dental Consultants:

Dr. Jennifer Martinez-Amores
305-401-7118
jamores@caringformiami.org

Dr. Ken Baker
904 - 806-3358
bakerhome612@gmail.com

Dr. Al Warren
772-285-0791
loualwarren@gmail.com

Hygienist Consultant:

Missy White EFDA, RDH
386-916-8565
Missywhite855@gmail.com

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Steps Toward an Effective Mission

Introduction

Planning is imperative for an effective mission. 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 mission. We realize that each mission is unique and has different needs. Feel free to customize your mission to meet the unique needs of your community.

Plan Ahead

A. Reserve the Mobile Dental Ministry:

Request to reserve the MDMU and/or the Preventive Care Portable Delivery System through Community Ministries of the Florida Baptist Convention. Requests can be submitted through the web site www.FLBaptist.org/MDU or by contacting your Community Ministries Catalyst at mjohnston@flbaptist.org.
If you are reserving the Preventive Care Portable Delivery System, please read the Preventive Care Section on pages 34-46.

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 Ministry Unit Coordinators. Other cost determined by the dental mission may include advertising, cost of copying forms, thank you gifts, meals for volunteers, Bibles, tracts, etc.

Select a Planning Team

The planning team should begin meeting approximately eight (8) months prior to your mission. Attached is a chart of team members and their duties. This chart will be helpful as you enlist your planning team. This is a suggested list, you may not want to use every position. Please note the asterisked positions are required, and all the duties listed need to be accounted for. The Preventive Care Director is only required if you are providing Preventive Care.

Position	Name	Team Member Duties
Pastor, Church Staff Member, Associational Mission Strategist, or Designee***		• Gives Overall Supervision & Guidance for the Mission. • Serves as liaison between the church and Florida Baptist Convention Community Ministries • Arranges for the Scheduling of the MDMU to come to the church. • Arranges for funds to be appropriated for the mission through the church or association budget. • Recruits Mission Director • Recruits Planning Team Members with Mission Director
Dental Mission Director***		• Provides general supervision to the mission. • Recruits Planning Team Members • Responsible for recruiting and scheduling Dentists, Dental Assistants, and Dental Hygienists to work in the mission. • Relates to the Vol. Health Services Regional Coordinator (VHSRC) for training of volunteers and completion of forms for Sovereign immunity. • If an associational mission, serves as the liaison between the team & the contact person at the church. • Assumes responsibility for the completion of all forms that are to be forwarded to the (FBC) & (VHSRC) • Leads in an evaluation of the mission. • Complete the screening & training required by the Florida Dept. of Health to be a designated DOH 110 Volunteer.
Assistant Mission Director		• Assists in the coordination of the mission. • Review patient folders to ensure required forms are complete prior to scheduled MDMU appointment • Provide daily dental appointment schedule • Provides dental kits for distribution during mission. • Complete the screening & training required by the Florida Dept. of Health to be a designated DOH 110 Volunteer.
Spiritual Care Coordinator***		• Responsible for recruiting & scheduling of spiritual care givers. • Provide witnessing & spiritual care training to all volunteers. • Provide a comfortable & welcoming setting for waiting patients. • Arrange for special activities with children. • Make available Bibles and gospel tracts.

Position	Name	Team Member Duties
Medical Screening Director***		• Medical background preferred but not required - Nurse, Dental Hygienist, Pharmacist, Paramedic, EMT, CNA, Etc. • Recruit medical screening volunteers • Complete Medical Record on each patient • Coordinate schedule for medical coverage during mission.
Preventive Care Director***		• Recruit dental hygienists. • Work with the Dental Mission Director to recruit Dental Hygienists • Coordinate Hygiene Appointment Schedule with the Dental Mission Director/Assistant Mission Director • Prepare and maintain the space for the portable operatory • Responsible for the set up and care of the Portable Delivery System and accompanying equipment
Volunteer Coordinator		• Assumes responsibility for the recruiting & scheduling of DOH 110 Volunteers to work during the prescreening and mission. • Recruit Appointment Volunteers • Arrange DOH 110 Training of volunteers with Dental Mission Director. • Assign volunteers patients to contact and remind of appointment. • Complete the screening & training required by the Florida Dept. of Health to be a designated DOH 110 Volunteer.
Meal Coordinator		• Plans and prepares daily meals for MDMU personnel, Dentists, Dental Assistants, Nurses & volunteers serving in the dental mission. • Provide snacks and drinks for patients waiting to be treated on the MDMU.
Advertising Coordinator		• Develop promotion strategy • Consider the use of social media • Develop flyers for distribution • Determine locations: local businesses, gas stations, convenience stores, library, social agencies, etc. • Create signs for prescreening and mission days. • Display MDMU signs at roadway intersections the day of prescreening and appointment week.
Dental Resources Compiler		• Discover dental resources in city/community such as: - Dental Colleges - Pro-bono Clinics - Assistance with dentures - Health Department Clinics • Provide a list with contact information for the patients.
Dental Assistant		• Provides dental screening. • Assist with scheduling patient appointments. • Chair assist dentist, if needed.
Dental Consultant		• Provide guidance for dental strategy. • Provides dental screening. • Assist in recruiting dental professionals.

Team Trainings and Meetings

A. Training provided by the Florida Baptist Convention—For all new missions, the Dental Mission Trainers or the Community Ministries Catalyst will provide training for the Dental Mission Director and Team Members. The training needs to take place about 7-8 months prior to your mission.

If needed, training will be provided for established dental missions. We always welcome the opportunity to provide guidance, additional training and help you find solutions to issues you have encountered.

B. Initial Team Meeting—Discuss/Review the following:

- Determine the location for the Mobile Dental Ministry Unit.
- The dates set for the mission 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 mission
- Forms that need to be completed before, during and after the mission
- Plans for witnessing and spiritual care during the mission
- Plans to make patients feel welcome and comfortable.
- Make arrangements for further care in case someone experiences pain or infection after the close of the mission.

C. Dental Mission Director to meet with the Volunteer Health Services Regional Coordinator (VHSRC)

Contact the VHSRC at the beginning of planning your mission. Contact information is listed on the back page. Regional Coordinators are assigned to counties. This person will provide the forms needed for Sovereign Immunity. This initial meeting should take place at least seven months prior to the dental mission.

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 mission

D. Periodic Team Meetings – The planning team should meet together periodically for members to report on progress of their assigned duties and to pray for the dental mission.

E. Department of Health 110 Volunteer Training – It is necessary for those volunteers who will serve as the DOH 110 volunteers to meet with the Volunteer Health Services Regional Coordinator for training prior to the dental mission. 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.

Determine the Location

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

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.

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 hazardous waste 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.

Determine the Mission Schedule

The mission 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 MDMU Coordinators.

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

***Additional Volunteers**

We would love to have additional volunteers to serve on the Mobile Dental Ministry Unit with us.

Reasons for Additional Volunteers:

- Heavy Patient flow expected
- Your Day exceeds 8 hours– MUST Recruit additional volunteers
- Dentist/ or Mission 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 MDMU 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 MDMU 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 mission. We may want to provide an opportunity for the volunteer to be trained on a mission prior to your mission.

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 35)-** This form lists the mission contact persons. Submit this form online at flbaptist.org/mdu immediately after the team has been elected.
B. **Dentists and Dental Assistants Schedule**– Our MDMU Coordinators make their travel plans according to this schedule. ***Please send in 3 weeks*** before the scheduled start date of your mission. Complete and submit online at flbaptist.org/mdu

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Planning for the Dental Mission

Time Line for Dental Mission

Phase One…. **7 to 8 months before Mission Date** ☐

- Submit *"Team Information Form"* online at flbaptist.org/mdu
- Make initial contact with Volunteer Health Services Regional Coordinator.
- Begin process of enlisting dentists, dental assistants, dental hygienists, 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 mission.

Phase Two…. **3 months before Mission Date** ☐

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

Phase Three…. **2 months before Mission 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 mission in associational and church newsletter to enlist additional volunteers.

Phase Four…. **1 month before Mission Date** ☐

- Have dentists and dental hygienist complete the ***VHCPP Dental Contract Application*** and submit them to your Volunteer Health Services Regional Coordinator's office.
- Send a reminder card to the dentists and dental hygienist 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 MDMU Coordinators, and contact them.
- Determine the supportive ministries for the children, such as puzzles, crayons, singing, videos, etc.

Phase Five…. **2 to 3 weeks before Mission 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.
- Send in the ***Schedule for Dentists, Dental Assistants, and dental hygienist*** to Community Ministries and VHSRC
- Conduct screening and make appointments for patients to see the dentist(s). Give each patient an appointment card.
- Confirm arrival time of MDMU and Preventive Care Trailer.
- Make sure dental kits are ready for distribution.

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

- Send Thank-You letters to dentists/dental assistants/ dental hygienists.
- Complete and submit Dental Summary Report online at FLbaptist.org/mdu
- Complete VHSRC Event Report (DOH Report).

Recruit the Dentists, Dental Assistants, and Dental Hygienists

A. Recruit dentists and dental hygienists at least 6-8 months prior to the mission. Dentists and dental hygienists schedule appointments in their office 6 months in advance, so you must enlist them early.

B. Ideas for recruiting dentists, dental assistants, and dental hygienist

1. Enlist a local dentist to help you recruit the other dentists for the mission.
2. Send a letter to the dentists and include the following: (sample letter provided on next page to be used with recruitment brochures)
   - *Use the dental preference form on page 36 to collect dental staff information and preferences. Fill in the times and dates on the form before giving to the dental staff.
   - *Florida Baptist Mobile Dental Ministry Unit is one of the affiliate agencies of the Project: Dentists Care, a project of the Florida Dental Association
   - *Dentists and dental hygienists 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 and dental hygienists 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 Ministry Unit. Brochures available 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 mission.
5. The Volunteer Health Services Regional Coordinator can provide ideas on how to recruit and who to contact.
6. Contact Community Ministries office for list of dentists and dentist assistants. We have complied a list of volunteers willing to serve. We may or may not have any in your area.

C. When a dentist or dental hygienist is enlisted, follow-up with a call, visit or card to confirm the location and time for their commitment. Include directions to the mission. Call one week before the mission 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)**- Florida 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
Dental Practice Name Dental Practice Address

Dear Dr. _____,

My name is _____ , and I am the Dental Mission Director for (Insert the name of your church and location). I would like to invite you to join our church in a dental mission to our community. We are excited to be partnering with the Florida Baptist Convention in the use of their Mobile Dental Ministry Unit. With your help, we hope to meet basic dentistry needs of the underserved in our community. The basic dentistry we hope to provide is fillings, extractions, and cleanings. The Mobile Dental Ministry Unit will be stationed at insert name of location and full address. The dates we have scheduled are insert the dates of your mission.

I have included a brochure about volunteering as a dental professional with the Florida Baptist Mobile Dental Ministry. I hope you have time to read through it as it contains information about Sovereign Immunity and Continuing Education Credits provided through Project: Dentists Care and the Florida Dental Association.

I have also included a Dental Staff Preference form. This form has the schedule for our dental mission. You may indicate on the chart which shift or shifts you would be interested in serving. Please include your dental assistant in this mission. I and my dental mission team know that this mission will be impossible without your help and the help of your assistant. We want to thank you in advance for your consideration and help.

I will look forward to hearing from you soon so that I can get your shifts confirmed, and begin the process for your Sovereign Immunity. Feel free to reach out to me with any questions you may have. You may also access information about the Florida Baptist Dental Ministry at https://flbaptist.org/mdu/ Once again, thank you in advance for your willingness to serve those in our community in need of dental care.

Respectfully,

Insert Dental Mission Director Name and contact information

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 are 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 Ministry 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

Each church or association Dental Mission 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).

For the Dentists and Dental Hygienists

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

Contract should be submitted one month prior to the mission.

A. The Dentist Contract will need to be renewed every 5 years. A sample Application can be found on page 37.

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

Sovereign Immunity (continued)

For the Dental Mission Director and those designated as DOH 110 Volunteers

New Dental Mission Directors will complete the chapter 110 Volunteer Application packet provided by the VHSRC. This will need to be completed and taken to your DOH training. At the training session, the Volunteer Health Services Regional Coordinator will have all volunteers complete the **Volunteer Participation Roster.**

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.**

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. Once the patient's paperwork is completed by the DOH 110 Volunteer, place the paperwork in a manila folder to protect the patient's privacy. (See Creating Patient Records on page 27)
2. 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 to protect the patient's privacy. (see Creating Patient Records on page 26)
3. Volunteers may then take the folder to the coordinators on the unit. Patient should not carry record
4. Never Discuss Patient's information within hearing distance of others.
5. Be sensitive of discussing patient's information in confines of Dental Bus. (That patient's friend or relative may be in the other chair).

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.

Pre-Mission Communication with MDMU Coordinators

A. Prepare for MDMU arrival

The Dental Mission Director will need to communicate with the Transportation/Maintenance engineer on the location of the mission. Someone needs to meet the MDMU when it arrives to show where to park the unit and help with the set up.

B. Prepare for MDMU Coordinators

- **Mission Start Day and Time needs to be communicated with MDMU Coordinators 2-3 weeks before the mission.**
- Church or Association is responsible for housing and meals.
- Dental Mission 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 Mission. They will provide receipts and left over money at the end of the mission. If you did not advance them enough funds, they will present receipts for reimbursement.
- MDMU Coordinator and Transportation Engineer contact information is listed on page 3

Final Check List

Please, use the form on the next page as a check list for your mission. Hopefully, this will help you in your preparation.

Final Check List

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

- ❑ 1. Completely read the Mobile Dental Ministry Unit Planning Manual.
- ❑ 2. **Sent Team Information Form to Community Ministries**
- ❑ 3. 110 Volunteer Application Packet completed by Dental Mission 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, dental hygienists 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 MDMU Coordinators.
- ❑ 14. Sent Dentist and Dental Assistants Schedule to Community Ministries and VHSRC.

NOTES:

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Conducting the Dental Mission

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 mission begins and may continue throughout the mission 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 mission 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. (Sample form on p53)

   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. (Sample form on p51) Note: If the patient is seen a second time or at the private office of volunteer dentist, a new VHCPP Referral Must be generated.

3. Medical Screening

   If a patient qualifies, the medical screening team member will help him fill out the ***Dental Medical Record*** and sign it. You will find this form in the manual on page 51-53. 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 54-55) 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 mainly do fillings and extractions. Inform the patient that they will receive treatment to get them out of pain.

   Preventive dental care is very important. The Mobile Dental Ministry Unit has been equipped with the tools for Dental Hygiene. Dental Hygiene needs to be planned ahead of time with the Community Ministries Catalyst. If you are not including hygiene in your Dental Mission, 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. <u>Stand-By Policy</u>
   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 MDMU 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.
   *Check previous records for how many patients the Dentist has seen in a session. (average is 10-12)
   *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.)

C. Communication with the MDMU Coordinator during mission:

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 MDMU 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. Records must be secured inside a file folder. You may staple the records or use a fastener file folder. Medical records are secured on the left side, on top of the DOH PATIENT Referral Form. The DOH ELIGIBILITY Form should be behind the DOH PATIENT Referral Form. Progress Notes should be the top form on the right side. Feel free to develop your own color coding system to help with easy retrieval of patient records.

Important Reminders During the Mission:

- **Church or Association is responsible for recruiting dental assistants. If a dentist does not bring an assistant, the local mission 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.
- Dental Mission Directors should not leave site without checking in with the MDMU Coordinators.
- At the end of the mission, you will complete separate reports for the VHCPP and Community Ministries. Please, review the requirements prior to starting the mission.

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 mission should be on meeting the needs of the individual - dental as well as spiritual needs.** The whole mission 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 MDMU. Some patients will be nervous about seeing the dentist. Comfort them! Give them the opportunity to talk, to share their story. Ask open-ended questions. 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 MDMU.

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)

Meeting the Spiritual Needs (continued)

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.

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.

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Finishing the Dental Mission

Forms to be Completed After the Mission

A. Complete and submit the following forms online at Flbaptist.org/mdu
1. Dental Mission Summary Report
2. Evaluation of Mobile Dental Mission

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.

Evaluate the Mission

The planning team should meet together to evaluate the mission from their perspective. Often the MDMU 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 mission. 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, dental hygienists and dental assistants. Let them know how much you appreciate them and how valuable they are to the mission. Include a stamped, self addressed card asking if they would commit to next year's mission. You may want to consider a small gift of appreciation after the mission or at another appropriate time during the year such as Christmas, etc. This will help build a relationship with the dentists and your mission.

Florida Baptist Convention MDU Provider Survey

This survey has been developed to allow you to gain the provider's input on your mission. You may hand this directly to the provider or include it in your thank-you letter.

Florida Baptist Convention MDMU Provider Survey

Name (optional): _____

1. Do you feel the Event Coordinator provided accurate communication regarding location, service times, and expectations about your role?
   Yes _____ No_____
   Comments:

2. Did the Event Coordinator provide punctual responses to your questions and concerns? Yes _____ No_____
   Comments:

3. Do you feel patients were screened appropriately for medical and dental issues and that the data collection accurately provided you with information to determine treatment eligibility and needs? Yes _____ No_____
   Comments:

4. Were the supplies and equipment on the bus adequate to provide the services you offered? Yes_____ No_____
   Comments:

5. On a scale of one to ten, rate the allotted patient appointment time, patient flow, and patient load for your volunteer hours served.
   1 2 3 4 5 6 7 8 9 10 (1 being poor and 10 being excellent)
   Comments:

(turn over to continue survey)

6. On a scale of one to ten, rate how well the MDU Bus Coordinator provided support while you were providing services. (Did they support you in locating your supplies, support you with room break down and set up, room sterilization, and patient flow?)

   1 2 3 4 5 6 7 8 9 10 (1 being poor and 10 being excellent)

   Comments:

7. On a scale of one to ten, rate the support and experience of the dental assistants.

   1 2 3 4 5 6 7 8 9 10 (1 being poor and 10 being excellent)

   Comments:

   Were you asked to bring your own dental assistants? Yes____ No ____

8. Did all team members you worked with exhibit professional behaviors and show diligent care and compassion to co-workers and patients?

   Yes____ No____

   Comments:

9. On a scale of one to ten, rate the dates, times, and location of the bus for you to be able to volunteer.

   1 2 3 4 5 6 7 8 9 10 (1 being very poor and 10 being excellent)

   Comments:

10. On a scale of one to ten, how likely are you willing to volunteer again based on your current experience with the Florida Baptist Convention Mobile Unit?

    1 2 3 4 5 6 7 8 9 10 (1 being not willing and 10 being definitely)

    Comments:

Mobile Dental Ministry
Florida Baptist Convention

Right Beside You.

Preventive Care

MOBILE DENTAL MINISTRY PREVENTIVE CARE

Since 1973, our main purpose has been to treat patients with primary dental needs—fillings and extractions. Patients receive treatment to get them out of pain. Preventive Care is extremely important in helping a person have good dental hygiene. In November 2021 the Florida Baptist Convention purchased a Portable Delivery System for Preventive Care along with the appropriate chairs. The Portable Delivery System is available to be used with the Mobile Dental Ministry Unit during a dental mission. Treatment for primary dental needs is still priority. We recommend finding a separate space for Preventive Care and using both operatories on the MDMU for treatment.

The following will help you prepare to include Preventive Care in your dental mission:

- **Reserve Portable Delivery System.** You will need to reserve, even if you already have the MDMU scheduled. Reserve by emailing Community Ministries Catalyst at mjohnston@flbaptist.org.

- **Select a Preventive Care Director for your Dental Mission.** Ideally this would be a dental hygienist or someone with dental background. See page 9 of the Mobile Dental Ministry Planning Manual for a list of duties.

- **Transporting the Portable Delivery System.** A 5'X8' trailer with a 2" ball requirement has been purchased to transport the Portable Delivery System, dental hygiene chairs, sterilization equipment, instruments, and supplies. The equipment and trailer are stored at First Baptist Church of Interlachen. Please contact Marc Johnston, Community Ministries Catalyst at 904-571-8037 to arrange picking up the equipment or have it delivered. Keep in mind that everything on the trailer will need to be moved into a climate-controlled space. The equipment is heat sensitive and cannot be stored in the trailer.

- **Dental hygienists and dentists must be recruited.** Dental professionals should be contacted six to eight months in advance. Ideas for recruiting are on page 16 of the Mobile Dental Ministry Planning Manual.

- **Dental hygienists along with dentists receive continuing education credits.** All dental professionals receive one continuing education credit per one hour of patient services provided through the Mobile Dental Ministry as stated on page 16 of Planning Manual. Certificates are provided on pages 86-87 of Planning Manual. Complete the certificates and give to the dental professionals when they complete their service.

- **Dental hygienists and dentists need to be contracted for sovereign immunity.** Since dental hygienists are licensed professionals, they need to be

contracted just like dentists. See page 18 of Mobile Dental Ministry Planning Manual.

- **If dentist is <u>not</u> onsite during the clinic,** hygienist will need to have malpractice insurance valued at $100,000 per occurrence and $300,000 aggregate. If hygienist doesn't have malpractice insurance, the church could offer to reimburse these costs. The cost is about $65.00 per year and can be purchased online within a few weeks prior to the event. This is the company that is recommended: https://www.proliability.com. (See Appendix **Florida Statutes**)

- **The dentist's role in Preventive Care:** The dentist must sign off on the patient's medical history (Dental Clinic Medical Record page 51 of Planning Manual) before the hygienist can treat the patient. You will need to ask a dentist to volunteer for this role. This can be done several ways:
    1. Secure a dentist and have him/her sign them at the prescreening days. This is ideal!!!
    2. Collect the medical histories at the prescreening, deliver them to the dentist and he/she will sign them and return to you. (Note, you cannot send these electronically unless you are using a HIPAA secure platform.)
    3. Have dentist to sign the medical histories as patients arrive for their appointment or at the beginning of the day.

- **Conduct Screenings for Patients and Schedule Appointments:**
    1. Financial Screening—See page 25 of Planning Manual.
    2. Medical Screening—See page 25 of Planning Manual. Pages 51-53 has the **Dental Medical Record** form provided in English, French and Spanish. If the patient has medical problems denoted on the medical form by an asterisk (*), a "Health Issues Authorization" Form (page 54-55) must be completed and signed by the patient's physician.
    3. The hygiene schedule should be a maximum of one patient per hour or as determined by the hygienist/dentist. This is much longer than patients receiving treatment such as fillings or extractions. See page 25 of Planning Manual.
    4. If a patient needs treatment as well as preventive care, schedule both a few days apart. Preventive care should be scheduled prior to extraction appointments. No preventive care after an extraction on the same week

- **Hygiene Consent Form must be completed.** All patients receiving preventive services without a comprehensive exam by a dentist must fill out an informed consent form as described in Statute 466.023. (See Appendix **Hygiene Consent Form**). You can make copies for each patient to sign upon appointment arrival. We suggest this form be completed after the patient signs the Dental Clinic Medical Record.

- **Follow HIPPA Policies**
    1. HIPPA and Guidelines to Protect Patient Privacy—See page 19 of Planning Manual.
    2. Creating Patient Records—See page 27 of Planning Manual.

- **Dental Resources Must Be Available**
    1. A list of area dentists or dental clinics must be offered to preventive patients and **suggest** they call to schedule a complete exam by a licensed dentist within 13 months of their appointment as outlined in Statute 466.023. This is the legal requirement.
    2. Go the extra mile! Provide patients with a list of dentists and/or dental clinics that will provide services on a pro bono basis or a sliding scale.
    3. This would be the responsibility of the Dental Resources Compiler. See page 9 of the Planning Manual.

- **Prepare and maintain space for your portable operatory.** See Appendix: **Site Specifications!** The site specification appendix lists an ideal situation. If you don't have everything listed, consider other ways of setting up the space. Be creative, even if you set up a tent! Access to power and water is non-negotiable. Water must be accessible and nearby. The space needs to be clean. During your scheduled preventive care training, the trainers will help you access your site. Containers and bags for medical waste will be provided. During your dental mission, MDMU Staff will dispose of regulated medical waste.

- **Equipment Storage and Handling!** See Appendix: **Equipment Storage and Handling** for safety precautions and proper use and storage of equipment. Your volunteer Dental Hygienists should be able to help with the care of equipment, MDMU staff will have MDMU responsibilities as their priority.

- **Completing the Dental Mission!** See page 31 of the Planning Manual.

- **For Information only!** This document was based on Florida State regulations as a 501C-3 established "Health Access Setting" as defined in Florida Statues. See Appendix **Florida Statutes.**

MDMU DENTAL HYGIENE INFORMED CONSENT:

The services being offered are not a substitute for a comprehensive dental exam by a dentist.

The diagnosis of caries, soft tissue disease, oral cancer temporomandibular joint disease (TMJ), and dentofacial malocclusions will be completed only by a dentist in the context of delivering a comprehensive dental examination.

It is encouraged that you establish a dental home and receive a dental exam by a dentist within 13 months, sooner if possible. You may elect to find a dentist on your own or choose one of the clinics in your area. You will be given a list of dentists or clinics to support you. We are in no way affiliated with these facilities and do not receive any referral, kickback, or brokering fees from them. We cannot determine the availability of appointments at these facilities, and you will need to call the numbers provided to determine appointment times and fees that you may incur.

I understand the above and agree that I will seek to find a dentist within the 13-month period for a comprehensive dental examination. I have been informed that services performed today do not include a dentist examination and comprehensive exam.

_____ _____

Signature Date

_____

Printed Name

ROOM SPECIFICATIONS

Site Specifications

Operatory

Sterilization Sink Area

Pictures are a sample of approximate space

- Room with AC and proper ventilation
- Minimum of two standard wall outlets
- Minimum size of 12 ft x 12 ft square footage
- Space is clean and empty of other equipment. (Free of mold, cobwebs, bugs, dust, dirt, chairs, toys, books, etc.)
- 6ft to 8 ft table with new plastic tablecloth
- Non- carpeted flooring if possible, but not required(You can modify the carpet area with a waterproof covering like office mats, piece of linoleum, or similar material that the chair can roll on and the surface can be cleaned.Three mats will be included on the trailer.)
- Locks on the doors or building to safeguard equipment when the clinic is not in use. (overnight)
- Near a bathroom if possible, but not required.
- Sink with water and a countertop as close as possible for the ultrasonic and sterilizer (clean side/dirty side)
- 2 gallons of distilled water per 8-hour day

EQUIPMENT STORAGE AND HANDLING

Equipment Storage and Handling

Equipment Storage and Handling

- Equipment should be handled gently to avoid breaking parts and pieces.
- **The mobile delivery unit must always stay upright**. Please do not tip it over while loading, unloading, and storage. **The delivery unit and other equipment should be strapped and secured during transportation** to avoid sliding around in the trailer causing damage. The cords and foot petal need to be secured. All tie downs will be provided.
- Dental supplies should be packed and transported in the plastic containers provided. Packed neatly and wrapping any breakable equipment with bubble wrap or plastic bags to avoid damage.
- The equipment should be **disinfected by trained personnel** before handling and packing. Please request dental hygienist to ensure proper disinfection.
- If you have any problems with the equipment functioning properly, please contact Missy White at 386-916-8565, your MDMU Coordinator, or Crystal and Farrell Crews at 904-868-8145. If they are not available, please use the owner manual and contact the manufacturer's service department. **Please do not attempt to repair any equipment on your own.**
- Please keep all boxes and bags for the equipment in a safe place during your clinic. Please return the Equipment and Supplies to their original containers and wrapped accordingly. Pictures and inventory lists are provided as a guide.
- **The equipment and supplies should not be left in high heat or severe cold at any time, other than a brief time during transportation. Room temperature is ideal. Please pack the trailer just before transporting to avoid equipment and supplies from being left outside in the elements for extending periods. The equipment and supplies can melt or be damaged.**
- Please return the equipment in the same condition it was received. Please keep the equipment protected in a locked room and away from unauthorized persons. (Children or adults should never be allowed to play with or touch the equipment, there are multiple risks for accidents. Please help us keep everyone safe.)
- If you have missing/broken supplies, parts, or equipment, or if you use the last of an item, please notify MDMU staff as soon as possible.
- After the equipment is removed, all surfaces in the room should be disinfected with an approved disinfecting cleaner. (1 part bleach/10part water ratio or Pine Sol/water according to label is what the MDMU uses.)

466.003 Definitions. —As used in this chapter:

(1) "Board" means the Board of Dentistry.

(2) "Dentist" means a person licensed to practice dentistry pursuant to this chapter.

(3) "Dentistry" means the healing art which is concerned with the examination, diagnosis, treatment planning, and care of conditions within the human oral cavity and its adjacent tissues and structures. It includes the performance or attempted performance of any dental operation, or oral or oral-maxillofacial surgery and any procedures adjunct thereto, including physical evaluation directly related to such operation or surgery pursuant to hospital rules and regulations. It also includes dental service of any kind gratuitously or for any remuneration paid, or to be paid, directly or indirectly, to any person or agency. The term "dentistry" shall also include the following:

(a) The taking of an impression of the human tooth, teeth, or jaws directly or indirectly and by any means or method.

(b) Supplying artificial substitutes for the natural teeth or furnishing, supplying, constructing, reproducing, or repairing any prosthetic denture, bridge, appliance, or any other structure designed to be worn in the human mouth except on the written work order of a duly licensed dentist.

(c) The placing of an appliance or structure in the human mouth or the adjusting or attempting to adjust the same.

(d) Delivering the same to any person other than the dentist upon whose work order the work was performed.

(e) Professing to the public by any method to furnish, supply, construct, reproduce, or repair any prosthetic denture, bridge, appliance, or other structure designed to be worn in the human mouth.

(f) Diagnosing, prescribing, or treating or professing to diagnose, prescribe, or treat disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws or oral-maxillofacial region.

(g) Extracting or attempting to extract human teeth.

(h) Correcting or attempting to correct malformations of teeth or of jaws.

(i) Repairing or attempting to repair cavities in the human teeth.

(4) "Dental hygiene" means the rendering of educational, preventive, and therapeutic dental services pursuant to ss. 466.023 and 466.024 and any related extra-oral procedure required in the performance of such services.

(5) "Dental hygienist" means a person licensed to practice dental hygiene pursuant to this chapter.

(6) "Dental assistant" means a person, other than a dental hygienist, who, under the supervision and authorization of a dentist, provides dental care services directly to a patient. This term shall not include a certified registered nurse anesthetist licensed under part I of chapter 464.

(7) "Department" means the Department of Health.

(8) "Direct supervision" means supervision whereby a dentist diagnoses the condition to be treated, a dentist authorizes the procedure to be performed, a dentist remains on the premises while the procedures are performed, and a dentist approves the work performed before dismissal of the patient.

(9) "Indirect supervision" means supervision whereby a dentist authorizes the procedure, and a dentist is on the premises while the procedures are performed.

(10) "General supervision" means supervision whereby a dentist authorizes the procedures which are being carried out but need not be present when the authorized procedures are being performed. The authorized procedures may also be performed at a place other than the dentist's usual place of practice. The issuance of a written work authorization to a commercial dental laboratory by a dentist does not constitute general supervision.

(11) "Irremediable tasks" are those intraoral treatment tasks which, when performed, are irreversible and create unalterable changes within the oral cavity or the contiguous structures or which cause an increased risk to the patient. The administration of anesthetics other than topical anesthesia is considered to be an "irremediable task" for purposes of this chapter.

(12) "Remediable tasks" are those intraoral treatment tasks which are reversible and do not create unalterable changes within the oral cavity or the contiguous structures and which do not cause an increased risk to the patient.

(13) "Oral and maxillofacial surgery" means the specialty of dentistry involving diagnosis, surgery, and adjunctive treatment of diseases, injuries, and defects involving the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. This term may not be construed to apply to any individual exempt under s. 466.002(1).

(14) "Health access setting" means a program or an institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene program in this state if such community service program or institution immediately reports to the Board of Dentistry all violations of s. 466.027, s. 466.028, or other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such setting.

(15) "School-based prevention program" means preventive oral health services offered at a school by one of the entities defined in subsection (14) or by a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c)(3) of the Internal Revenue Code.

466.023 Dental hygienists; scope and area of practice.—

(1) Except as otherwise provided in s. 466.024, only dental hygienists may be delegated the task of removing calculus deposits, accretions, and stains from exposed surfaces of the teeth and from the gingival sulcus and the task of performing root planing and curettage. In addition, dental hygienists may expose dental X-ray films, apply topical preventive or prophylactic agents, and perform all tasks delegable by the dentist in accordance with s. 466.024. The board by rule shall determine whether such functions shall be performed under the direct, indirect, or general supervision of the dentist.

(2) Dental hygienists may perform their duties:

(a) In the office of a licensed dentist;

(b) In public health programs and institutions of the Department of Children and Families, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist;

(c) In a health access setting as defined in s. 466.003; or

(d) Upon a patient of record of a dentist who has issued a prescription for the services of a dental hygienist, which prescription shall be valid for 2 years unless a shorter length of time is designated by the dentist, in:

1. Licensed public and private health facilities;
2. Other public institutions of the state and federal government;
3. Public and private educational institutions;
4. The home of a nonambulatory patient; and
5. Other places in accordance with the rules of the board.

However, the dentist issuing such prescription shall remain responsible for the care of such patient. As used in this subsection, “patient of record” means a patient upon whom a dentist has taken a complete medical history, completed a clinical examination, recorded any pathological conditions, and prepared a treatment plan.

(3) Dental hygienists may, without supervision, provide educational programs, faculty or staff training programs, and authorized fluoride rinse programs; apply fluorides; instruct a patient in oral hygiene care; supervise the oral hygiene care of a patient; and perform other services that do not involve diagnosis or treatment of dental conditions and that are approved by rule of the board.

(4) The board by rule may limit the number of dental hygienists or dental assistants to be supervised by a dentist if they perform expanded duties requiring direct or indirect supervision pursuant to the provisions of this chapter. The purpose of the limitation shall be to protect the health and safety of patients and to ensure that procedures which require more than general supervision be adequately supervised. However, the Department of Children and Families, Department of Health, Department of Juvenile Justice, and public institutions approved by the board shall not be so limited as

to the number of dental hygienists or dental assistants working under the supervision of a licensed dentist.

(5) Dental hygienists may, without supervision, perform dental charting as provided in s. 466.0235.

(6) Dental hygienists are exempt from the provisions of part IV of chapter 468.

(7) A dental hygienist may administer local anesthesia as provided in ss. 466.017 and 466.024.

466.0235 Dental charting. —

(1) For purposes of this section, the term "dental charting" means a recording of visual observations of clinical conditions of the oral cavity without the use of X rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets.

(2) A dental hygienist may, without supervision and within the lawful scope of his or her duties as authorized by law, perform dental charting of hard and soft tissues in public and private educational institutions of the state and Federal Government, nursing homes, assisted living and long-term care facilities, community health centers, county health departments, mobile dental or health units, health access settings as defined in s. 466.003, and epidemiological surveys for public health. A dental hygienist may also perform dental charting on a volunteer basis at health fairs.

(3) Each person who receives a dental charting pursuant to this section, or the parent or legal guardian of the person, shall receive and acknowledge a written disclosure form before receiving the dental charting procedure that states that the purpose of the dental charting is to collect data for use by a dentist at a prompt subsequent examination. The disclosure form shall also emphasize that diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions can only be completed by a dentist in the context of delivering a comprehensive dental examination.

(4) The board shall approve the content of charting and disclosure forms to be used under this section. Both forms shall emphasize the inherent limitations of dental charting and encourage complete examination by a dentist in rendering a professional diagnosis of the patient's overall oral health needs.

(5) Dental charting performed under this section is not a substitute for a comprehensive dental examination.

(6) Medical clearance by a physician or dentist is required before a periodontal probe may be used on a person who receives a dental charting.

(7) Nothing in this section shall be construed to permit direct reimbursement for dental charting performed under this section by Medicaid, health insurers, health maintenance organizations, prepaid dental plans, or other third-party payors beyond what is otherwise allowable by law.

(8) All referrals made in conjunction with the provision of dental charting services under this section shall be in strict conformance with federal and state patient referral, anti-kickback, and patient brokering laws.

(9) A dental hygienist performing dental charting without supervision shall not be deemed to have created either a patient of record or a medical record.

466.024 Delegation of duties; expanded functions.—

(1) A dentist may not delegate irremediable tasks to a dental hygienist or dental assistant, except as provided by law. A dentist may delegate remediable tasks to a dental hygienist or dental assistant when such tasks pose no risk to the patient. A dentist may only delegate remediable tasks so defined by law or rule of the board. The board by rule shall designate which tasks are remediable and delegable, except that the following are by law found to be remediable and delegable:

(a) Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance.

(b) Placing periodontal dressings.

(c) Removing periodontal or surgical dressings.

(d) Removing sutures.

(e) Placing or removing rubber dams.

(f) Placing or removing matrices.

(g) Placing or removing temporary restorations.

(h) Applying cavity liners, varnishes, or bases.

(i) Polishing amalgam restorations.

(j) Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth.

(k) Obtaining bacteriological cytological specimens not involving cutting of the tissue.

(l) Administering local anesthesia pursuant to s. 466.017(5).

This subsection does not limit delegable tasks to those specified herein.

(2) A dental hygienist licensed in this state may perform the following remediable tasks in a health access setting as defined in s. 466.003 without the physical presence, prior examination, or authorization of a dentist:

(a) Perform dental charting as defined in s. 466.0235 and as provided by rule.

(b) Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature.

(c) Record a patient's case history.

(d) Apply topical fluorides, including fluoride varnishes, which are approved by the American Dental Association or the Food and Drug Administration.

(e) Apply dental sealants.

(f) Remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus.

1. A dentist licensed under this chapter or a physician licensed under chapter 458 or chapter 459 must give medical clearance before a dental hygienist removes calculus deposits, accretions, and stains from exposed surfaces of the teeth or from tooth surfaces within the gingival sulcus.

2. A dentist shall conduct a dental examination on a patient within 13 months after a dental hygienist removes the patient's calculus deposits, accretions, and stains from exposed surfaces of the teeth or from tooth surfaces within the gingival sulcus. Additional oral hygiene services may not be performed under this paragraph without a clinical examination by a dentist who is licensed under this chapter.

This subsection does not authorize a dental hygienist to perform root planing or gingival curettage without supervision by a dentist.

(3) For all remediable tasks listed in subsection (2), the following disclaimer must be provided to the patient in writing before any procedure is performed:

(a) The services being offered are not a substitute for a comprehensive dental exam by a dentist.

(b) The diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions will be completed only by a dentist in the context of delivering a comprehensive dental exam.

(4) This section does not prevent a program operated by one of the health access settings as defined in s. 466.003 or a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c)(3) of the Internal Revenue Code from billing and obtaining reimbursement for the services described in this section which are provided by a dental hygienist or from making or maintaining any records pursuant to s. 456.057 necessary to obtain reimbursement.

(5) A dental hygienist who performs, without supervision, the remediable tasks listed in subsection (2) shall:

(a) Provide a dental referral in strict compliance with federal and state patient referral, anti-kickback, and patient brokering laws.

(b) Encourage the establishment of a dental home.

(c) Maintain professional malpractice insurance coverage that has minimum limits of $100,000 per occurrence and $300,000 in the aggregate through the employing health access setting or individual policy.

(6) Notwithstanding subsection (1) or subsection (2), a dentist may delegate the tasks of gingival curettage and root planing to a dental hygienist but not to a dental assistant.

(7) All other remediable tasks shall be performed under the direct, indirect, or general supervision of a dentist, as determined by rule of the board, and after such formal or on-the-job training by the dental hygienist or dental assistant as the board by rule may require. The board by rule may establish a certification process for expanded-duty dental assistants, establishing such training or experience criteria or examinations as it deems necessary and specifying which tasks may be delegable only to such assistants. If the board does establish such a certification process, the department shall implement the application process for such certification and administer any examinations required.

(8) Notwithstanding subsection (1) or subsection (2), a dentist may not delegate to anyone other than another licensed dentist:

(a) Any prescription of drugs or medications requiring the written order or prescription of a licensed dentist or physician.

(b) Any diagnosis for treatment or treatment planning.

(9) Notwithstanding any other provision of law, a dentist is primarily responsible for all procedures delegated by her or him.

(10) A dental assistant may not perform an intraoral procedure except after such formal or on-the-job training as the board by rule shall prescribe.

NOTES:

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Forms to use Before the Unit Arrives

Team Information

Note: Submit immediately after the team has been elected.

Church or Association: _____ Date: _____

Mission Dates: _____

Tentative Locations: _____ Address: _____

_____ Address: _____

PASTOR, CHURCH STAFF MEMBER, AMS, OR DESIGNEE:

PHONE: _____

E-MAIL ADDRESS: _____

MISSION DIRECTOR: _____

PHONE: _____

E-MAIL ADDRESS: _____

SPIRITUAL CARE COORDINATOR: _____

PHONE: _____

E-MAIL ADDRESS: _____

MEDICAL TEAM DIRECTOR:

PHONE: _____

E-MAIL ADDRESS: _____

Number for Patients to Call: _____

Complete and submit online at Flbaptist.org/mdu

Dentist Staff Preference Form

Dental Mission:_____
Dental Mission Date:_____

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

Times:	Day Date:	Day: Date:	Day: Date:	Day: Date:	Day: Date:

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
- ☐ Blood Thinners
- ☐ Baby Aspirin
- ☐ Adult Aspirin

Sovereign Immunity:

- ☐ I need
- ☐ I Already Have

Dental Assistant to serve with Me: _____
Phone:_____ Email: _____
Address: _____
City: _____ Zip: _____

VOLUNTEER HEALTH SERVICES
VOLUNTEER HEALTH CARE PROVIDER PROGRAM (VHCPP)
APPLICATION for SOVEREIGN IMMUNITY CONTRACT

Provider's Full Name:_____
(LAST) (FIRST) (MI)

Address:_____
(Street) (City) (State) (Zip)

Phone Number: (_____)_____ E-mail Address:_____
(Include Area Code) (Optional)

Occupation: _____Specialty:_____ FL License Number:**DN9853**

It is recommended by the Department of Health that individual providers, applying for a VHCPP contract for sovereign immunity protection, and who are affiliated with a Professional Association, (P.A.)/Group, also establish a Sovereign Immunity contract to protect the P.A/Group and its employees.

Please indicate if you would like a Corporate contract if you are affiliated with a P.A/Group.
CHECK APPROPRIATE RESPONSE, SIGN AND DATE THE FORM

Yes _____ No _____
(If Yes, please complete the following information)

Signature: _____ Date: _____

P A/Group Corporation Name: _____

Printed Name of Corporate Officer/Director with Contract Authority: _____

Business Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)
Mailing Address (if different from above address): _____

Phone Number: (_____) _____-_____ FEI or Document Number:_____

IN ORDER TO PROTECT CLIENTS A ROUTINE CHECK OF THE FLORIDA MEDICAL LICENSE AND CORPORATION NAME WILL BE MADETHROUGH THE FLORIDA DEPT OF HEALTH MEDICAL QUALITY ASSURANCE AND/OR THE FLORIDA DIVISION OF CORPORATIONS

License/Corporation Verification (for DOH use only)

Individual
Current Florida Health Professional License? Yes _____ No _____
License Status "Clear and Active? Yes _____ No _____
Corporation:
Active and Registered Florida Corporation? Yes _____ No _____

Verification Completed By: _____
(Signature of VHCPP Regional Coordinator) Date

This completed application can be mailed to Lori Thompson, Dept. of Health, Volunteer Health Services, 200 San Sebastian View, St. Augustine, FL 32084, or emailed to Lorraine.Thompson2@flhealth.gov Be sure to indicate if you do or not want a contract for your Professional Association.

Revised 3/15/18

sample

Dentist and Dental Assistants Schedule

Complete and submit at www.flbaptist.org/mdu

DAY OF THE WEEK					
TIME: DENTIST:	MORNING	MORNING	MORNING	MORNING	MORNING
DENTAL ASSISTANT:					
TIME: DENTIST:	AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON
DENTAL ASSISTANT:					
TIME: DENTIST:	EVENING	EVENING	EVENING	EVENING	EVENING
DENTAL ASSISTANT:					

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Forms to use During the Mission

Dental Clinic Medical Record
Florida Baptist Convention –Community Ministries

BP____/____ Pulse_____ Date_____ Initials_____ BP____/____ Pulse_____ Date_____ Initials_____

Name: _____ Age: _____ DOB: _____

A. Do you(Patient) have or had any of the following:

			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 ( ) **DATE:**				
*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 another Drug reaction				
Tuberculosis **DATE:** _____				
Sexually Transmitted Disease, Herpes				
High Blood Pressure (No action require if under control with medication)				
Infectious Hepatitis (A, B, or C) **DATE:**				
Artificial Joints (i.e., hip, knee, elbow) **DATE:**				
HIV Positive, ARC (Aids Related Complex) or Diagnosed with AIDS				
Allergies: Please list below (Latex?)				
*Cancer Currently on Chemotherapy or Radiation **DATE:**				
Fosamax or Medication for Osteoporosis/Osteopenia **DATE STARTED:**				
Have you taken any street drugs in the past 3 days?				

B. Have you ever experienced any unfavorable reaction from previous dental treatment? Yes No

C. Are you currently under care of a Physician? Yes No

D. Have you been hospitalized or in the Emergency Room in the last 2 years? Date/ Why? _____ Yes No

E. Are you taking any Medications? Please list below or 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.

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 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 the 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 Mission Volunteer** Signature of Dentist **Date**

Rev. 8/2022

Historial Médico de la Clínica Dental
Convención Bautista de Florida –Ministerios a las Comunidades

BP____/____ Pulso_____ Dia_____ Iniciales_____ BP____/____ Pulso_____ Dia_____ Iniciales_____

Nombre: _____ Edad: _____ Fecha de Nacimiento: _____

A. Usted (Paciente) ha tenido algo de lo siguiente:

			SI	NO
Asma: *Traiga su Inhalador con usted*				
Diabetes: Tipo 1 Dependiente de Insulina ( ) Tipo 2 ( ) *Coma normal antes de la cita*				
Epilepsia: Día del último ataque? _____				
Problema Cardiovascular: Infarto ( ) Derrame ( ) Dolor de pecho ( ) *Reemplazo de Válvula ( ) *Defecto de válvula ( ) * Defecto del corazón ( ) Fiebre reumática en la infancia ( ) Soplo en el corazón ( ) **DIA:**				
*Anticoagulantes (i. e. aspirina, aspirina de bebe, Coumadin, Plavix, etc.)				
Marcapaso				
Enfermedad del Hígado o Riñón (Se requiere el OK del Dr si estas en *diálisis.)				
Reacción a la Penicilina o a algún otro medicamento				
Tuberculosis **DIA:** _____				
Enfermedad de transmisión sexual, Herpes				
Presión Alta (No se requiere ninguna acción si está bajo control con medicamentos)				
Hepatitis Infecciosa (A, B, o C) **DIA:**				
Articulaciones artificiales (i.e., cadera, rodilla, codo) **DIA:**				
Positivo al HIV, ARC (Trastorno inmunológico relacionado con el SIDA) o Diagnosticado con SIDA				
Alergias: haga una lista abajo (¿Latex?)				
*¿Está pasando por Quimioterapia o Radiación por cáncer? **DIA:**				
Fosamax o Medicamento por Osteoporosis/Osteopenia **DIA QUE COMENZO:**				
¿Has tomado alguna droga en las calles en los pasados 3 días?				

B. Has experimentado reacción desfavorable en algún tratamiento dental previo? Yes No

C. Estas bajo el cuidado de un médico primario? Yes No

D. Has estado hospitalizado o en la sala de emergencias en los últimos 2 años? Día/Porqué? _____ Yes No

E. Estas tomando algún medicamento? Por favor escríbalos abajo o utilice la parte de atrás de la hoja Yes No

F. Si eres mujer, Estas *Embarazada? Trimestre 1 2 3 Yes No

Si pusiste algún SI en la parte A a la E, Explica aquí:

_____

_____

_____

Observaciones Adicionales: _____

Si tienes algunos de estos problemas de salud, Debes tener una forma de autorización completada para poder ser atendido por el médico de la Unidad Dental móvil.

Consentimiento para _____, localizada en _____. Los operadores de la Unidad Dental Móvil de la Convención Bautista de Florida y cualquier dentista o proveedor de atención médica o agente autorizado que me examine o trate para divulgar mi información médica protegida para diagnóstico y tratamiento u operaciones de atención médica, incluida cualquier información recibida de otros proveedores de atención médica. Este aviso estará vigente durante un año a partir de la fecha de su firma. Entiendo que este consentimiento se puede retirar.

Reconozco lo anterior y recibo el Aviso de derechos de privacidad. Declaro que la información médica anterior es precisa.

_____ _____ _____

Firma del Paciente o Guardian **Firma del Voluntario de la Mision Dental** **Día**

_____

Firma del Dentista

Rev. 8/2022

Dental Clinic Medical Record
Florida Baptist Convention –Community Ministries

Pression Artérielle ____/____ Pouls_____ Dâte _____ Initiale _____ Nom: _____
Age: _____ DDN _____

A. Souffrez-vous ou avez-vous souffert des maladies suivantes:

			OUI	NON
Asthme: *Apportez votre inhalateur avec vous.*				
Diabète: Type 1 Insulino-dependent ( ) Type 2 ( ) Mangez avant le rendez-vous				
Epilepsie: Dâte de la dernière crise? _____				
Maladie Cardiaque: Arret Cardique ( ) Accident Vasculaire Cérébrale ( ) Douleur Thoracique ( ) *Replacement de valve au coeur ( ) *Anomalies des valves du cœur ( ) * Malformation Cardiaque ( ) Fièvre Rhumatismale ( ) Bruit anormal au cœur ( ) **DATE:**				
*Anticoagulants (c-a-d: Aspirin, Aspirin pour bébés, Coumadin, Plavix, etc.)				
Stimulateur Cardiaque				
Maladie des Reins ou du Foie (Autorisation d'un Médecin est obligatoire en cas de *Dialyse pour maladie des reins.)				
Pénicilline ou toute autre réaction médicamenteuse				
Tuberculose **DATE:** _____				
Maladies Sexuellement Transmissibles, Herpès				
Hypertension artérielle (Aucune action est nécessaire si vous prenez des médicaments)				
Hépatite Infectueuse (A, B, or C) **DATE:**				
Jointures Artificielles (c-a-d., hanche, genoux, épaules) **DATE:**				
Séropositif pour VIH (Virus de l'Immunodéficience humaine).				
Allergies: Enumérez les allergies au-dessous (Latex?)				
*Cancer: Actuellement sous chimiothérapie ou radiothérapie **DATE:**				
Fosamax ou autres médicaments pour Osteoporosis/Osteopenia **DATE:**				
Avez-vous consommé des drogues illicites au cours des trois dernières années ?				

B. Avez-vous expérimenté des complications après un traitement dentaire? Oui Non

C. Êtes-vous actuellement sous les soins d'un médecin? Oui Non

D. Avez-vous été hospitalisé ou dans une salle d'urgence au cours des deux dernières années ? Date/ Pourquoi? Oui Non

E. Prenez-vous des médicaments ? Énumérez ci-dessous Oui Non

F. Pour les femmes seulement, "Êtes-vous enceinte? Trimestre 1 2 3 Oui Non

Si vous cochez "Oui" dans les parties A à E, veuillez expliquer ici :

_____

_____

Remarques Aditionnelles _____

Si vous avez l'une des conditions mentionnées, vous devez compléter une Forme d'Autorisation afin de recevoir les soins de la Clinique Dentaire

Consentement donné à _____ situé à _____. Les employés de l'Unité Mobile Dentaire de la Convention Baptiste de la Floride et tout dentiste ou prestataires de soins de santé peuvent partager mes informations de santé en cas de diagnostic ou de traitement, y compris toute information reçue d'autres prestataires de santé. Cet avis sera en vigueur pendant un an à compter de la date de signature. Je comprends que ce consentement peut être annulé. J'atteste la validité de ce qui précède et la réception de l'avis de Droits de Confidentialité. Je déclare que les informations médicales ci-dessus sont vraies et exactes.

_____ _____ _____

Signature of Patient or Guardian **Signature of Dental Mission Volunteer** **Date**

_____

Signature of Dentist

Rev. 8/2022

HEALTH ISSUES AUTHORIZATION EXPLANATION

This is a mandatory form given to patient to take to their physician in certain medical circumstances. **This form depend on the Dentist/Dental Hygienist preferences Form** and patients medical history. This form and medical questionnaire will be facilitated by a medical team member.

1. **Patient Name and Date of Birth.** Please complete this section at top of form

2. **Health issues.** Check appropriate box concerning patients issue. Feel free to note explanation, blood pressure results, etc. To help physician understand the request.

- **Blood thinners.** Request should only be sent when a volunteer dentist, that accepts patients taking blood thinner, is not available. Only patients who are planned for an extraction procedure should receive this form. Patients who are only receiving a filling do not need this form. As volunteers we can **NEVER** tell patients to stop medication, only their physician can.

- **Valve Replacement, Valve defect, Heart defect.** All patients stating they have this condition should receive this form. Their Physician may want them to take antibiotic prior to receiving dental work.

- **Artificial joint, hip, knee, other.** All patients stating they have this condition should receive this form. Their Physician may want them to take antibiotic prior to receiving dental work.

- **Pregnancy.** All pregnant women must receive approval from their physician or OBGYN to receive treatment.

- **Cancer currently on Chemo or Radiation.** This request is only for those patients who have recently stopped or are in the currently on cancer treatment. Their Physician may want them to take antibiotic prior to receiving dental work.

- **Kidney Dialysis**. Patients must receive this forms as physician will determine which day this patient can receive dental treatment. Dental treatment must normally be on a different day than their Dialysis appointment.

- **HIV.** Their physician may want them to take antibiotic prior to receiving dental work.

- **High Blood Pressure.** A Patient should receive this form if the medical screener or dentist deems their blood pressure is too high. Please check on current blood pressure recommendations from the American Heart Association. These recommendations change from year to year. If patient states they are taking blood pressure medications you can consider them under control.

3. **Physician Authorization**. This section must be completed by Physician only.

Health Issues Authorization Form **Patient Name: _____ DOB _____**

During your medical assessment for receiving dental care, it was revealed that you have one of the following medical 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

- ☐ 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
- ☐ Kidney Dialysis
- ☐ HIV
- ☐ High Blood Pressure

Physician Authorization

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

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

Blood Thinners Stop taking _____ / _____days prior to dental appointment.

Artificial Joint: Take _____ dosage_____ _____(time) prior to appointment time.

Kidney Dialysis _____

High Blood Pressure _____

Physicians comments/recommendations:
_____
_____

Physicians Signature: _____

Physician's Printed Name: _____ Date: _____

MUST HAVE FORM COMPLETED OR NO SERVICES WILL BE PROVIDED

Rev. 8/2022

PROGRESS NOTES EXPLANATION

This form gives your Health Care volunteers an opportunity to share information considering they are seeing patient at different times and maybe different locations. This form should be place under Medical History.

1- Patient name and Date of Birth. All patients documents should have this information.

2- Medical Screener's Notes: This can be used to explain reason Nurse has chosen to give patient a health issue Authorization form, it may be used to comment on patients medications. It is a place for nurses to write any information they may want Dentist to know pertaining to patient.

3- Dental Screener's Notes. This area may be used by triage volunteer or Dental Hygienist or Dental Assistant on screening day to communicate hurting tooth location, pain level or anything else may help Dentist in diagnosis of patient complaint.

4- Dentist Progress Notes. This area is for dentist to write summary of treatment done for patient. This is optional area, if used should have **"X" in Lieu of signature, see progress notes.**

*** If your Mobile Dental Mission chooses not to use recommendations and chooses instead to allow dentist to fit his notes in the small space provided, they will not need to rewrite in DENTAL PROGRESS NOTE area. The Dentist is only required to write their progress note in one place.

PROGRESS NOTES

In lieu of signature on form DH 1032

Florida Baptist Convention Mobile Dental Ministry Unit

Name: _____DOB: _____/_____/_____

Medical Screener's Notes

_____

_____

_____

Signature of Medical Screener: _____ Date: _____

Dental Screener's Notes

Please document only the most urgent needs; not everything that needs attention.

1. Chief Complaint:/ Location of pain_____

2. Pain: YES _____ NO _____

3. Patient requests

_____

4. Notes:

_____

_____

_____

Signature of Dental Personnel _____ Date: _____

Dental Providers Progress Notes

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Dentist: _____ Date: _____

Exam # _____ $ _____ X-Rays # _____ $_____ Fillings # _____ $ _____ Extractions # _____ $_____

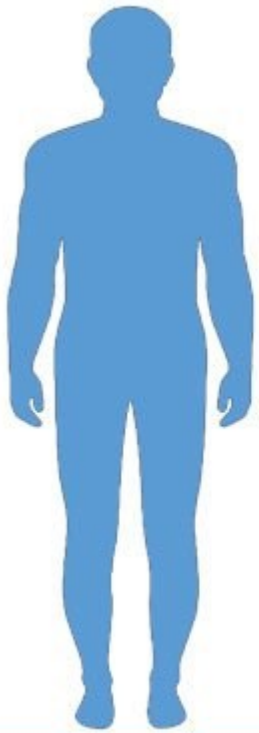
Cleaning: Type _____ $ _____ Fluoride _____ $_____ Sealant _____ $ _____

Oral Irrigation _____ $_____

TOTAL ESTIMATED VALUE OF HEALTH CARE PROVIDED $ _____

Rev. 8/2022

Female	Age	SBP	DBP
	21-25	115.5	70.5
	26-30	113.5	71.5
	31-35	110.5	72.5
	36-40	112.5	74.5
	41-45	116.5	73.5
	46-50	124	78.5
	51-55	122.5	74.5
	56-60	132.5	78.5
	61-65	130.5	77.5

Male	Age	SBP	DBP
	21-25	120.5	78.5
	26-30	119.5	76.5
	31-35	114.5	75.5
	36-40	120.5	75.5
	41-45	115.5	78.5
	46-50	119.5	80.5
	51-55	125.5	80.5
	56-60	129.5	79.5
	61-65	143.5	76.5

Guideline to Common Blood Thinning Medications

The following Anticoagulants need Health Authorization Form for the patient to be seen for extraction if a dentist who accepts patients on blood thinners is not available:

Coumadin (Warfarin)
Angiomax (Bivalirudin)
Argatroban
Pradaxa (Dabigatran)
Iprivask (Desirudin)
Eliquis (Apixaban)
Bevyxxa (Betrixaban)
Savaysa (Edoxaban)
Arixtra (Fondaparinux)
Xarelto (Rivaroxaban)
Heparin
Lovenox (Enoxaparin)
Fragmin (Dalteparin)

The above Anticoagulants and the following Antiplatelets and Thrombolytics are okay for fillings:

Antiplatelets:
Pletal (Cilostazol)
Kengreal (Cangrelor)
Plavix (Clopidogrel)
Effient (Prasugrel)
Brilinta (Ticagrelor)
Zontivity (Vorapaxar)
Agrylin (Anagrelide)
Aggrenox (Dipyridamole/Aspirin)
Persantine (Dipyridamole)
ReoPro (Abciximab)
Integrillin (Eptifibatide)
Aggrastat (Tirofiban)
Aspirin 81mg
Aspirin 325mg

Thrombolytics:
Defitelio ((Defibrotide)
Ceprotin (Protein C Concentrate)
Activase and Cathflo (Alteplase)
Retavase (Reteplase)
TNKase (Tenecteplase)

Volunteer Healthcare Provider Program Patient Referral Form Explanation

This form will be covered in details by Department of Health Service Coordinator. A recommendation is to highlight the areas to give guidance to intake volunteer. The particular area that will be covered in this explanation is focused on the last section at the bottom of form.

If you choose to modify this section of the form or add highlight areas, you must request the form from your VHPPC in Word format.

In lieu of signature, see Progress Report notes. This is again in the last section. This is optional. Below are bullets of explanation.

- This small area does not leave the Dentist enough room to record legally require information pertaining to patients treatment. According to chapter 466, Statue 466.018, (3) 'Every dentist shall maintain written dental records, medical history records, which justify the course of treatment of the patient. The record shall include, but is not limited to, patient history, examination results, test, results and if taken X-rays.

- Additionally, the dentist must record their treatment, all in this small box.

- Since dentist are accustomed to writing their long notes in their offices in computers or on a Progress report, we have provided a progress report form to insert in your patient record. Your volunteer dentist may write this required information at bottom of the form labeled DENTIST PROGRESS NOTES.

sample

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
PATIENT REFERRAL FORM

Referral #

NOTICE TO PATIENT

You are being referred to a volunteer health care provider who will provide free care to you or someone for whom you are legally responsible. Depending on the determination of the volunteer health care provider, you may also receive services from pathologists, laboratories, radiologists, and anesthesiologists. Your participation in this referral process is voluntary. The care you receive from the volunteer health care professionals will be provided at no charge to you. However, you may be billed for pharmaceuticals. The health care providers are providing care on behalf of the State of Florida and each serves as an agent of the State. By acceptance of this referral, you acknowledge that the state solely is liable for any injury or damage suffered by you, or someone that you permit to receive treatment, that results from authorized treatment by the volunteer providers and that the State's liability is limited as found in section 768.28, Florida Statutes (copy provided)

I hereby certify that I have read the above notice and understand that I am being referred to a volunteer health care provider who will provide free care for me or someone for whom I am legally responsible. I further understand the volunteer health care provider may also refer me to pathologists, laboratories, radiologists, and anesthesiologists whose specialized services may be needed to treat my health condition. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever she/he may designate as assistants). In addition, I certify that the information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge.

I also acknowledge I am responsible to inform the clinic of any change in my financial or health insurance status.

Signature: _____ Date: _____

If treatment is for a minor, indicate relationship to child

Patient's Name: Date of Birth:

Address: Sex: Male Female

Race: White Black Asian/PI
Am Indian/Alaskan Native

Phone: Ethnicity: Hispanic Non-Hispanic

Eligibility: *(check one)* DOH client/patient 200% poverty or less Medicaid eligible *(no provider available)*

Referral Type: Medical Care Dental Care Other *(specify)*

Notes:

_____
Print Name of DOH Referring Person

_____ _____
DOH Referring Person's Signature Date

Referred to:

Address/Phone:

As needed, the above-named health care provider is referring this patient to the following health care providers who are under contract as outlined in section 766.1115, Florida Statutes, and are agents of the state:

Pathologist Laboratory Radiologist Anesthesiologist

Response to Referral Originator:
(actual services provided)

Date of Initial Service Received _____

Estimated Value of Health Care Provided $

☐

_____ _____
Volunteer Health Care Provider Signature Date

☐ In lieu of signature, see progress notes.

DH 1032 (12/14), 64I-2.002(5), F.A.C.

ORIGINAL-To Patient Medical Record COPY-To Patient at Time of Referral
COPY-To Provider as Needed

sample

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: FBC Mobile Dental Unit @ Wellborn Baptist Church, Wellborn, FL 32094

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES _____ NO _____
Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2
Family Size: Adults____ Under 18 ____ **18-21--Student ____** **Unborn _____** **Family Size TOTAL _____**

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI)
SELF			**$**	**$**
SPOUSE/PARTNER			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
		TOTALS	**$**	**$**
		Add earned and unearned income to determine total		**TOTAL INCOME $_____**

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. "TOTAL FAMILY INCOME" for family unit (Earned and unearned income). (1) $_____ (Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $_____ (Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____ (Minus)

(3a) $_____ (Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

Step 5. **TOTAL NET INCOME** (5) $_____ (Total)

Section 4 **USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION**

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN

PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE

DATE: _____

(VALID FOR ONE YEAR) Expiration date: _____

DH 1032E (12/14), 64I-2.002(4), F.A.C.

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.

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.

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**.**

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.

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.

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.

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

_____

(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"

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.

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 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.

MOBILE DENTAL MINISTRY UNIT

VOLUNTEER SIGN-IN SHEET

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

POST-OPERATIVE INSTRUCTIONS

These instructions are designed to minimize bleeding, prevent dry sockets and improve comfort.

Δ Bite on gauze for 30 minutes. Repeat as necessary using firm, steady pressure or bite on a cold, wet tea bag and keep your head elevated. This should significantly control bleeding; however, slight oozing of blood is to be expected.

Δ For the next 24 hours:
- **Keep head elevated**
- **Food/drink should be cold, cool or room temperature**
- **Apply ice pack to outside of face over the surgical area. Alternate 20 minutes on 10 minutes off**

Δ Beginning 24 hours after procedure:
- **Gently rinse mouth with warm, salty water (1/2 tsp / 8 ounces) 3 times a day for 3 days**
- **Brush teeth carefully avoiding surgical areas**

Δ For 4 days after the procedure:
- **Do not smoke**
- **Do not spit/suck**
- **Do not use a straw**
- **Do not use commercial mouthwash**
- **Do not use hydrogen peroxide**
- **Do not drink carbonated or fizzy beverages**

Δ Eating Instructions:
- **You may begin drinking/eating after the gauze is removed**
- **Cold, cool or room temperature food the first day**
- **Soft food for comfort. No nuts, seeds or sharp food**
- **Eating something before you begin pain pills will help prevent nausea**

Δ You can expect:
- **To see diluted blood in your mouth for 2-3 days**
- **To swell around the surgical site**
- **To be very sore for at least 4 days (3rd day is the worst)**
- **To gradually feel more comfortable after one week**
- **To have bad breath for 1-2 weeks**

Do not drink alcohol, drive or operate machinery while taking narcotic pain medication.

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 (Ibuprophen), lie down and try to relax. If you continue to have a problem, call _____.

INSTRUCCIONES PARA EL POSTOPERATORIO

Estas instrucciones están designadas para minimizar el sangrado, prevenir resequedad en la herida y sentirse mejor.

- ✓ Muerde una gaza por 30 minutos. Repítelo si es necesario presionando de forma firme, o muerde una bolsita de te mojada y fría y mantén tu cabeza en posición elevada. Esto debe de controlar significativamente el sangrado. Es normal una ligera supuración de sangre.

✓ **Para las próximas 24 horas:**

- Mantén tu cabeza en posición elevada
- Comida/bebida debe de ser fría o a temperatura ambiente
- Aplica bolsa de hielo sobre la cara en el área de la cirugía por 20 minutos y descansa 10 minutos y así sucesivamente.

✓ **24 horas después del procedimiento sigue las siguientes instrucciones:**

- Cuidadosamente enjuágate con agua salada y tibia (1/2 taza/8 onzas) 3 veces al día por 3 días
- Cepíllate los dientes cuidadosamente, evitando tocar el área de la cirugía.

✓ **4 días después del procedimiento sigue las siguientes instrucciones:**

- NO fume
- NO escupa o succione
- NO use absorbente (popote, pajilla, carrizo, etc.)
- NO use enjuagues bucales
- NO use Agua Oxigenada
- NO beba agua carbonatada o bebidas gaseosas

✓ **Instrucciones para comer:**

- Debes de comenzar a beber/comer después que hayas removido la gaza
- Comida fría, o a temperatura ambiente por el primer día
- Comidas blandas. No semillas (nueces o comida dura)
- Come algo antes de tomarte las pastillas del dolor para prevenir las nauseas

✓ **Que puedes esperar:**

- Ver un poco de sangre en tu boca de 2 a 3 días
- Inflamación alrededor del área de la cirugía
- Sentirte bastante adolorido por al menos 4 días (el tercer día un poco más)
- Después de una semana, gradualmente debe sentirse mejor.
- Mal aliento por al menos 1 o 2 semanas

No beba alcohol, maneje o opere una maquinaria mientras este tomando medicinas narcóticas para dolor.

Si el dolor persiste después que recupere la sensación en su boca, puede tomar medicamentos no recetados como Tylenol (Acetaminofén) o Advil (Ibuprofeno), recuéstese y trate de relajarse. Si continúa teniendo algún problema llame a: _____

INSTRUCTIONS POST-OPERATIVE

Ces instructions visent à minimiser les saignements, à prévenir les prises sèches et à améliorer le confort.

- Mordre sur gazon pendant 30 minutes. Répétez aussi nécessaire en utilisant l'entreprise, la pression constante ou mordre sur un sac de thé froid et humide et garder la tête haute. Cela devrait contrôler de toutes évidences les saignements; Cependant, on peut s'attendre à un léger reniflement du sang.

- Pour les prochaines 24 heures

  Gardez la tête haute
  La Nourriture/boisson doit être froide, fraîche ou température ambiante
  Appliquer le pack de glace à l'extérieur du visage au-dessus de la zone arctique. Alternez 20 minutes à 10 minutes

- À partir de 24 heures après la procédure:

  Haussement de la bouche avec de l'eau chaude et salée (1/2 tsp / 8 onces) 3 fois par jour pendant 3 jours
  Brosser soigneusement les dents en évitant les zones surgicales

- Pendant 4 jours après les procédures:

  Ne fumez pas
  Ne crachez pas/
  N'utilisez pas de paille
  N'utilisez le mouthwash commercial
  N'utilisez pas de peroxyde hydrogène
  Ne buvez pas de boissons gazeuses ou de boissons gazeuses

- Instructions Alimentaires:

  Vous pouvez commencer à boire / manger après la gaze est enlevée
  Nourriture froide, fraîche ou de température de chambre le premier jour
  Nourriture douce pour le confort, pas de noix, de sans-robes ou d'aliments pointus
  Manger quelque chose avant de commencer des analgésiques aidera à prévenir les nausées

- Vous pouvez vous attendre à:

  Voir du sang dilué dans votre bouche pendant 2-3 jours
  Voir inflammation autour du site de l'opération
  Pour être très douloureux pendant au moins 4 jours (3eme jour est le pire) Pour se sentir progressivement plus à l'aise après une semaine
  Avoir une mauvaise haleine pendant 1-2 semaines

Ne buvez pas d'alcool, ne conduisez pas ou n'exploitez pas de machines tout en prenant des analgésiques narcotiques

- Notifiez-nous immédiatement pour:

  Vomissage répété Saignement incontrôlé Fièvre de 101 degré F ou plus

  - Entre 8h et 17h, appelez la clinique dentaire au (386) 326-3336
  - En cas d'urgence médicale, veuillez appeler votre salle d'urgence locale

Si la douleur persiste après le retour de la sensation dans votre bouche, vous pouvez prendre n'importe quel médicament en vente libre tel que Tylenol (acétaminophène) ou Advil (ibuprophène), vous allonger et essayer de vous détendre. Si vous continuez à avoir un problème, appelez _____.

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 PM
fecha *hora*

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 PM
fecha *hora*

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: _____
_____
_____

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: _____
_____
_____

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Forms to use after the Mission

Dental Mission Summary Report

Complete and submit the form at flbaptist.org/mdu

The following information will be required to complete the form:

Church / Association: _____ Date: _____

1. Number of Patients: _____ Adults: _____ Children: _____
2. Number of Vol. Dentists: _____ Total Hours Vol. _____
3. Number of Dental Assistants: _____ Total Hours Vol: _____
4. Number of Dental Hygienists: _____ Total Hours Vol: _____
5. Number of Other Volunteers: _____ Total Hours Vol: _____
6. Number of Preventive care services: _____
7. Number of Fillings: _____
8. Number of Extractions: _____
9. Total Value of Services Offered: $ _____
10. Number of referrals to outside sources: _____
11. Total hours of clinic operations: _____
12. Number of Evangelistic Encounters: _____
13. Number of Profession of faith: _____
14. Number of other decisions: _____

Dentists	Email Address	Phone	Hours Volunteered
Dental Assistants	Email Address	Phone	Hours Volunteered
Dental Hygienists	Email Address	Phone	Hours Volunteered

Evaluation of Mobile Dental Mission

Complete and submit the form at flbaptist.org/mdu

Church / Association: _____ Date of Mission: _____

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 Community Ministries Team at the Florida Baptist Convention? ❑ Yes ❑ No
3. Was the training provided by the Dental Mission trainers or C.M Catalyst helpful? Why or why not
   _____
   _____
   _____
   _____
4. What do you feel was accomplished through your mission? _____
   _____
   _____
   _____
5. What can be done locally to improve this type of mission in the future? How can the Community Ministries Team assist you in improving the mission? _____
   _____
   _____
   _____
6. How would you evaluate the ministry of the MDMU Coordinators? _____
   _____
   _____
   _____
7. Did your volunteers have witnessing opportunities? ❑ Yes ❑ No
   If not, in what ways can you meet spiritual needs next year? _____
   _____
   _____
   _____
   _____
8. Were dental kits given out to your patients? ❑ Yes ❑ No
9. Additional Comments: _____
   _____
   _____
   _____
   _____

Mobile Dental Ministry | Right Beside You.
Florida Baptist Convention

Resources

Letter to Patients

The *sample* letter on the following page can be used as a witnessing tool for your patients and may be reproduced for your mission. 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 Mission

Because We Care...

Florida Baptist Mobile Dental Ministry 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 Ministry Unit. 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 for 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 Ministry Unit

Porque nos Importa...

Unidad Móvil Dental de la Convención Bautista de Florida

Estimados amigos,

Que privilegio para nosotros el poder llegar a usted en el nombre de nuestro Señor Jesucristo y ministrar en su necesidad física. Podemos tratarle hoy porque hay muchas personas que juntos han hecho posible este servicio sin ningún costo para usted.

El Señor nos dice en Mateo 25:40 “El Rey les responderá: “Les aseguro que todo lo que hicieron por uno de mis hermanos, aun por el más pequeño, lo hicieron por mí” Es un gozo para nosotros bendecirle porque el Señor nos bendijo primero. Él ha hecho posible este día. Él ha traído estos dentistas a través del cuidado de los Bautistas del Sur que han comprado esta unidad móvil y ha provisto personas que la atiendan. Ha llamado personas para apoyar financieramente. Y ha permitido que la Convención Bautista de Florida traiga este servicio a la comunidad. ¿Porque hacemos esto? Porque amamos al Señor Jesucristo y queremos ser una extensión de Su amor hacia ti.

No estás aquí por accidente. Dios en su vasto plan ha hecho posible que escucharas de esta clínica. Él ha provisto un lugar en las citas solo para ti. Él quiere que tu sepas cuanto te ama y que tiene planes maravillosos para tu vida. Sera un placer para nosotros compartir contigo como tú puedes tener una relación personal con El Dios Todopoderoso del universo. El desea que le conozcas personalmente para que puedas experimentar todo lo que él ha planeado para tu vida. En Su Palabra él nos dice: “Pues yo sé los planes que tengo para ustedes —dice el Señor—. Son planes para lo bueno y no para lo malo, para darles un futuro y una esperanza”. Jeremías 29:11
Si tu no estas experimentando los planes que Dios ha preparado para ti, por favor acércate a unos de nuestros ayudantes y pídeles ayuda. Sera un honor para nosotros responder las preguntas que tengas y ayudarte a descubrir cuan diferente y maravilloso es vivir en el camino que Él ha planeado para nosotros. Por favor permite que el personal y los voluntarios respondan las preguntas acerca del cuidado de Dios para ti, por eso estamos aquí.

El personal del Ministerio de la Unidad Móvil Dental

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

_____
Dental Mission Director

_____
MDMU Coordinator

Florida Baptist Convention | *Right Beside You.*

Revised 08/2022

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

_____
Dental Mission Director

_____
MDMU Coordinator

Florida Baptist Convention | *Right Beside You.*

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) 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) 516-7736
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

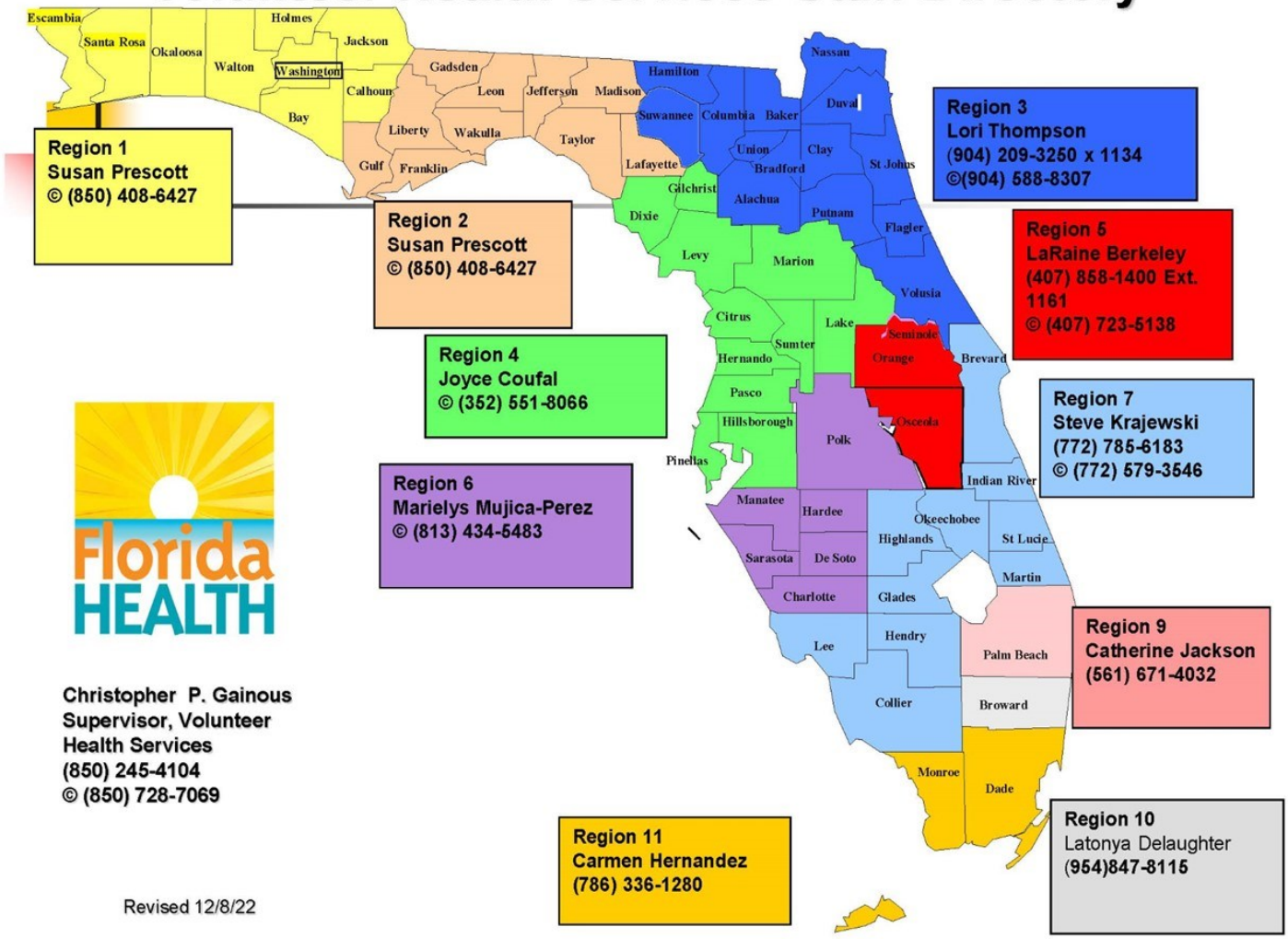
REGION 7 – Brevard, Collier, Glades, Hendry, Highlands, Indian River, Lee, Martin, Okeechobee, St. Lucie
Steve Krajewski
Florida Department of Health in St. Lucie County
5150 NW Milner Drive
Port St. Lucie, FL 34983
Phone: (772) 785-6183, © (772) 579-3546
Fax (772) 595-1306
E-mail : Steven.Krajewski@flhealth.gov

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
Latonya N Delaughter
Florida Department of Health in Broward County
780 Southwest 24th Street, Ste. 207
Fort Lauderdale, FL 33315
Phone: (954) 847-8115
Phone : © (954) 895-1807
E-mail : **latonya.delaughter@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

Volunteer Health Services Staff Directory



Florida HEALTH

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

Revised 12/8/22