

****IMPORTANT!! PLEASE RETURN THIS FORM PROMPTLY!!****

CITY OF MANCHESTER ORAL HEALTH PROGRAM



Easterseals NH
Oral Health Center
555 Auburn Street
Manchester, NH Tel: (603) 621-3482



City of Manchester
Department of Health
1528 Elm Street
Manchester, NH Tel: (603) 624-6466



Catholic Medical Center
88 McGregor Street Suite 305
Manchester, NH Tel: (603) 663-6226

PERMISSION FORM

Dear Parent or Guardian:

Your child may be eligible for the City of Manchester Oral Health Program. This program is specifically for children who are not currently under a dentist's care. The dental treatment, provided by a NH licensed dentist and dental staff at school on the dental van, will include dental exam, x-rays, cleaning, and fluoride treatment, and may include sealants and minor fillings to restore tooth function. In some cases a temporary filling will be placed by the Certified Public Health Dental Hygienist until your child can be seen at the dentist's office.

STOP: If you HAVE a dentist or you DO NOT wish to participate in the City of Manchester Oral Health Program, DO NOT complete OR return this form.

Student Information

Child's Name: (FIRST) (LAST) Date of Birth: / / circle (one) Male / Female
Address: Apt #: Telephone No.: Cell:
City: Zip Code: Preferred Language:
School: Grade: Teacher:
Ethnicity: Hispanic Non-Hispanic Race (check all that apply): White Black / African American American Indian / Alaskan Native Asian Native Hawaiian / Other Pacific Islander

Your Child's Health History

Your Child's Dental Health History

Name of Physician: Name of Dentist:
Is child taking any medicine: Date of last dental visit:
If so, what? Does child see a dentist regularly or for emergencies only?
Does child have any allergies? Have you any concerns about your child's teeth?
If so, to what? Explain:
Has your child had any of the following?: (Please yes or no to all questions)
Heart Murmur Yes No Physical Limitations Yes No
Asthma Yes No ADHD/ADD Yes No
Rheumatic fever Yes No Seizures or epilepsy Yes No
Other medical conditions in your child's health history?
Please explain:

Financial Eligibility Guidelines (please check the appropriate box below)

- My child has Medicaid and does not have a dentist
There is no cost to you for these services, but we must have the Medicaid number and your signature
Medicaid Number: _____
- My child does NOT have Medicaid or any other dental insurance coverage and my family's annual income falls in the range circled below. I agree to pay \$10 for dental services provided by the City of Manchester Oral Health Program if required to do so by the guidelines outlined below.
(Please send cash or check payable to Manchester Health Department when you return this permission slip to your child's school).

Please circle your family size and gross annual income level.

# of family members	Your Family's gross ANNUAL income	You Pay	# of family members	Your Family's gross ANNUAL income	You Pay	# of family members	Your Family's gross ANNUAL income	You Pay *
2	\$0-\$19,850	\$0	2	\$19,851-\$35,450	\$0	2	\$35,451-\$56,750	\$10
3	\$0-\$22,350	\$0	3	\$22,351-\$39,900	\$0	3	\$39,901-\$63,850	\$10
4	\$0-\$24,800	\$0	4	\$24,801-\$44,300	\$0	4	\$44,301-\$70,900	\$10
5	\$0-\$26,800	\$0	5	\$26,801-\$47,850	\$0	5	\$47,851-\$76,600	\$10
6	\$0-\$28,800	\$0	6	\$28,801-\$51,400	\$0	6	\$51,401-\$82,250	\$10
7	\$0-\$30,800	\$0	7	\$30,801-\$54,950	\$0	7	\$54,951-\$87,950	\$10
8	\$0-\$32,750	\$0	8	\$32,751-\$58,500	\$0	8	\$58,501-\$93,600	\$10

* No eligible child will be denied services because of a family's inability to pay
(Sliding fee scale based on City of Manchester HUD Income Guidelines - 2019)

PLEASE READ AND SIGN THIS INFORMED CONSENT

- I GIVE PERMISSION** for my child to participate in the City of Manchester Oral Health Program, provided on the dental van during school hours. This care WILL include a dental exam, x-rays, cleaning and fluoride treatment and MAY include sealants, fillings and/or temporary fillings. A local anesthetic, most commonly known as Novocaine, may be applied.
- I have received a copy of the City of Manchester Oral Health Program Notice of Health Information Practices for Release of Health Information in compliance with the privacy regulations of HIPAA and am aware of its contents. I authorize the Manchester Health Department to exchange medical/dental information between Easterseals Oral Health Center, Catholic Medical Center Poisson Dental Facility, Manchester Community Health Center and/or NH Medicaid.
- If my child HAS Medicaid, I authorize the release of medical information to Medicaid concerning treatment. I assign to the Manchester Health Department, Easterseals New Hampshire and/or Catholic Medical Center Dental Facility all payments for medical services rendered to my dependent as appropriate. I understand that I may be contacted by the providing agency or the Medicaid Program for further information.
- If my child DOES NOT have Medicaid, I have reviewed the Financial Eligibility Guidelines and have enclosed cash or a check for \$10 made payable to the Manchester Health Department, if applicable. **No eligible child will be denied services because of a family's inability to pay.**
- I certify that all information provided in this form is true to the best of my knowledge.

Signature of Parent/Legal Guardian: X _____

Date: _____