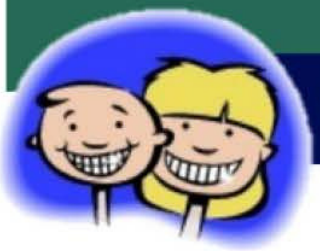


SKIPPY+

Tri-County Health Network's Cavity Prevention Program

Enrollment Form

In partnership with your child's school, Tri-County Health Network (TCHNetwork) is pleased to offer Skippy+, a school based dental program providing comprehensive dental care to your child. Our services bring dental care to your child so that she/he can spend more time in the classroom and less time traveling to a dentist!

The preventive dental visit takes about 30 minutes and gets your child back in the classroom quickly.

TCHNetwork has been providing Skippy for more than 10 years in schools throughout Montrose, Ouray, Delta and San Miguel Counties. We have held over 100 dental clinics, providing more than 7,000 treatments to local children.

Skippy+ is effective! Skippy+ has reduced the percentage of children with untreated decay to 20%, **9% below the national average.**

Services Provided:

If you agree to have your child participate in Skippy+, our dental team will provide:

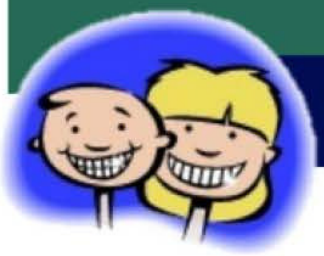
- Cleaning
- Exam by a Dentist
- X-Rays
- Fluoride treatment
- Protective Sealants and Interim Temporary Restorations (ITR), when necessary
- Free toothbrush, toothpaste and floss
- Take home form about child's oral health
- Education to your children how to brush and floss
- Referrals for any needed follow-up/restorative care (i.e. filings) (additional consent required)
- Forwarding your child's records/x-rays to your dentist of choice
- Health insurance enrollment assistance

Cost:

- Skippy+ is offered at no out of pocket costs to all families
- If you have dental insurance, we will bill for services just like other dental offices but you will not be billed for any outstanding fees

Risk:

- The materials used, and dental care provided, are the same as those in dental offices
- Dental care may have risks that are rare and minimal
- Dental hygienists provide the care in partnership with a dentist who follows standard dental procedures that include wearing latex free gloves, facemasks, sanitation and eye shields



SKIPPY+

Tri-County Health Network's Cavity Prevention Program

Privacy Policy:

- Information collected in this program will be kept private, unless required by law or to bill your insurance and will be shared only within the Skippy+ program
- If your child does not have health insurance. TCHNetwork Navigators will contact you to discuss potential health insurance options

Withdrawal:

- Participation is voluntary; your child does not have to participate in Skippy+ and can be revoked at any time by calling 970-708-7096
- This consent is valid for the entire school year, both fall and spring semesters, unless revoked

Rights:

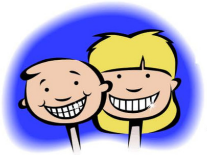
- Ask questions and have them answered to before and after signing the consent form
- Contact TCHNetwork at 970-708-7096 or email info@tchnetwork.org

To Enroll Your Child in the Program:

- Complete and Sign the "Health History Form"
- Return the form to your school Administration **2 weeks** before the clinic

Tri-County Health Network's Cavity Prevention Program

Health History/Consent Form



CHILD'S PERSONAL INFORMATION

First Name: _____ Middle Initial: ____

Last Name: _____

School: _____

Grade: ____ Birthdate: ____ / ____ / _____ Male O Female O

Parent/Guardian First Name: _____

Parent/Guardian Last Name: _____

Home Phone: (___) ___ - ____ Cell: (___) ___ - ____

Address: _____

City: _____ State: ____

Zip: _____

Email: _____

Language spoken at home: English O Spanish O Other O

Child's Race/Ethnicity: (check ALL that apply)

Black/African American O American Indian/Alaskan Native O Asian O Native Hawaiian or other Pacific Islander O White O

Hispanic or Latino O Not Hispanic or Latino O I do not wish to answer O

CHILD'S Health History

1. Has your child ever had serious health problems? YES O NO O If yes, for what? _____
2. Is your child under a doctor's care now? YES O NO O If yes, for what? _____
3. Please mark any illness or condition your child has EVER had:

   Epilepsy O Asthma O Heart Murmur O Convulsions/Seizures O Diabetes O

4. Is your child taking any medications at this time? YES O NO O If yes, for what? _____
5. Is your child allergic to latex? YES O NO O
6. Does your child have a dentist? YES O NO O

Dentist Name: _____

7. Do you need help finding a dentist? YES O NO O
8. Date last seen by a dentist: ____ / ____ / _____
9. Is there anything you like to tell us about your child regarding his/her dental experience? YES O NO O If yes, please explain: _____
10. Is your child eligible for free or reduced lunch? YES O NO O

Questions please call TCHNetwork at 970.708.7096

SKIPPY ID # _____

56311

PAYMENT INFORMATION - YOU MUST COMPLETE AND SIGN AT BOTTOM

If you have Dental Insurance, Medicaid or CHP+ we will bill for SKIPPY services. If your child presently receives oral hygiene care with a dentist, participation in Skippy is a duplication of those services and can result in denied insurance coverage for dental care.

Does your child have health insurance? YES O NO O

Carrier Name:

Does your child have Medicaid? YES O NO O **If yes, Medicaid ID #*:**

Does your child have CHP+? YES O NO O **If yes, CHP+ ID #*:**

If you do not know your child's Medicaid/CHP+ ID# provide your child's Social Security#: ___ - ___ - ____

Does your child have dental insurance? YES O NO O **If yes complete the information below**

Name of Dental Insurance Co:

Phone #: ( ) -

Dental Insurance Billing Address:

City: State: Zip:

Subscriber/Policyholder First Name:

Last Name:

Male O Female O Birth Date: / /

Plan/Group #:

Subscriber ID#:

Employer Name:

Employer Address:

City: State: Zip:

CONSENT: The information on this page and the health history are correct to the best of my knowledge. I agree and authorize Tri-County Health Network's (TCHN) licensed dental hygenists to perform any preventive dental procedures on my child and that no X-rays are taken. I understand this program does not take the place of an examination by a local dentist. I further understand that for the sustainability of the program, my insurance will be billed, if applicable. I request and authorize the release of any information on this form and acquired in the course of treatment for payment & referral purpose as deemed necessary by TCHN. I also authorize TCHN to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to TCHN. I also authorize TCHN to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to TCHN, as applicable. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to TCHN.

Parent/Guardian Signature:_____ Date: / /

Print Name:_____ Phone: ( ) -

THIS CONSENT WILL BE VALID FOR ENTIRE SCHOOL YEAR UNLESS REVOKED

Please return this form to the school no later than 2 weeks before Skippy

SKIPPY ID #

56311