Give Back a Smile Dentist Procedures, Protocol and Expectations

Dear Give Back a Smile (GBAS) dentist volunteer,

Thank you for your generosity in sharing your cosmetic skills with survivors of domestic violence who desperately need to regain their smiles and interact socially. Please review the following procedures, protocol and expectations.

1. The GBAS office has initially approved your patient by review of the submitted patient application; however, you are responsible for making the final determination of eligibility based on the program guidelines. **It is your patient's responsibility to call and schedule her/his consultation appointment.** Please inform the GBAS office if your patient does not schedule her/his consultation appointment within 30 days. The purpose of your initial consultation is to determine if your GBAS patient fits the guidelines of the program. If you determine your patient does not fit the criteria, please contact GBAS at 800.543.9220 or at givebackasmile@aacd.com.
2. All GBAS applicants are required to either pay a $20 application fee which also serves as a contribution to the Foundation or complete 10 hours of community service prior to GBAS application submission. This requirement is to encourage more investment in their dental treatment and to add a sense of value for the "gift" they may receive.
3. The patient must have received the injuries to her/his smile-zone from an abusive, intimate partner or spouse; husband, wife, partner, boyfriend, girlfriend, someone applicant dated or had a child with, and has been out of an abusive relationship for at least one year. All other situations, even if traumatic, including, without limitation, patient's injuries caused by child abuse, elder abuse, sibling abuse, caregiver abuse, parent abuse, violent attacks not related to intimate partner violence, stranger assault, or accidental injury, do not qualify and must be denied eligibility by the dentist. The cause of the qualifying injury is initially verified by an advocate based on the patient application.
4. The GBAS Program Guidelines *do not* cover severe dental neglect, decay, jaw injuries, pre-existing gum disease, or orthodontic treatment. You, as the dentist, make the final guideline determination and have flexibility in deciding what treatment to complete in these specific areas.
5. The program is designed to focus on standard of care-smile-zone dentistry, not full-mouth reconstruction. You are free to restore more than the injured area, if you wish, but this is not an expectation of the program.
6. The program guidelines *do not* allow for the repair or replacement of previous dental work, such as in a pre-existing root canal treated tooth, an implant placed in the injured area, or a fixed or removable prosthesis that has been lost or is ill-fitting. You have flexibility in deciding what treatment to complete in these specific areas.
7. The GBAS program does not guarantee specialist referrals, i.e. implants, orthodontics, or oral surgery procedures. If you are able to perform these procedures or can engage a specialist with whom you work to donate these services, please feel free to coordinate your treatment plan.
8. If laboratory work is needed, please work with your local laboratory(ies) to obtain a donation of the work needed. If your laboratory is unable to donate, please contact the GBAS office at 800.543.9220 or e-mail givebackasmile@aacd.com for a participating volunteer laboratory referral.
9. In addition to disqualifications for eligibility reasons, you can also *disqualify* a patient from the GBAS program for all or any of the following reasons: failing to show up for appointments, cancelling appointments, or cancelling appointments without 48-hour notice.
10. Once your GBAS case is complete, submit the "GBAS Final Report" form (page 5) by faxing it to 608.222.9540 or mail it to 402 West Wilson St, Madison, WI 53703. **You will not receive credit for completing your case until this form is received by the GBAS office.**
11. When your GBAS case is complete and the "GBAS Final Report" form (page 5) has been submitted, you are *not required* to perform maintenance to any of the dental work performed. The GBAS case is closed.
12. All GBAS patients are expected to be held accountable however, survivors of domestic violence may present long-term effects of violence. Be prepared for the possibility that your GBAS patient may exhibit these characteristics: depression, high risk of alcohol and drug problems, past and present, difficulty with accountability, inadequate hygiene, and difficultly with expressing appreciation of your time.
13. If you need to discontinue treatment for any reason, please contact the GBAS office immediately and we will guide you through termination protocol.

14. By participating in the GBAS program, you, at your sole cost and expense, are agreeing to (i) comply with all insurance requirements and with all laws, statutes, ordinances and regulations, including without limitation, any ethical guidelines, of Federal, state, county and municipal authorities which shall impose any duty upon you with respect to the GBAS program or your services thereunder; (ii) indemnify, covenant, defend and hold GBAS harmless from and against any damage, liability, loss, cost or deficiency, and the reasonable fees, disbursements and expenses of attorneys and other professional advisors), directly or indirectly, arising out of, resulting from or relating to your failure to duly perform or observe any term, provision, covenant or agreement to be performed or observed pursuant to the GBAS program; (iii) carry any and all insurance as would be prudent under the circumstances; and (iv) be solely responsible for any and all treatment decisions made with respect to your patient.
15. If you approve this case, a HIPAA form is included on pages 3-4 and must be signed by you and your patient and faxed to GBAS at 608.222.9540. Please keep a copy for your records.

HIPAA FORM

AUTHORIZATION FOR DENTISTS TO DISCLOSE CLIENT INFORMATION TO GIVE BACK A SMILE

THESE TWO PAGES MUST BE COMPLETED BY THE PATIENT AND THE DENTIST IN ORDER TO FOLLOW HIPAA GUIDELINES
FAX ONE COPY TO GBAS AT 608.222.9540

Purpose: This form is for client to authorization for use or disclosure of his/her protected health information to the Give Back A Smile program (GBAS) for accurate records reflecting the client's participation.

SECTION A: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Conditions: For GBAS participation, completion of this form is required. If not signed, we may not be able to assist you. Information we obtained from this form will be used by GBAS to support its charitable functions.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. For example, GBAS may need to disclose your information to its auditors.

SECTION B: The use and/or disclosure being authorized.

Purpose of this Authorization: To document donated cosmetic dentistry services provided to you through GBAS and costs associated with such services, including the GBAS's final case report. (See attached final report).

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe what protected health information this authorization is permitted to be use and/or disclose:

- Client's Name:
- Before and after photos:
- Description of dental procedures performed:
- Value of services rendered (office visits, laboratory costs, specialists, miscellaneous):

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), authorized to make use of and/or disclose the protected health information described above:
[Name of Treating Dentist]_____

Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), authorized to receive and use the protected health information described above:

Give Back A Smile program **American Academy of Cosmetic Dentistry**

SECTION C: Expiration and revocation.

Expiration: This authorization expires when treatment is completed and GBAS has received a final case report.

Right to Revoke: You may revoke this authorization at any time by providing written notice of revocation to the contact office listed below. Revocation of this authorization will *not* affect any action taken in reliance on this authorization prior to receiving written notice of revocation.

Contact Office: _____[Treating Dentist's Privacy Official]

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming authorization for use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, for example, a mother on behalf of a minor child, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Include this authorization in the client's dental records.
Send copy to the dentist's privacy official.
Send copy to:
Give Back a Smile
402 West Wilson Street
Madison, WI 53703
Or Fax to:
608.222.9540

Give Back A Smile Case Final Report

Complete and submit this form when your Give Back A Smile (GBAS) case is completed or after the case has been declined or closed. Please include before and after photographs from your records and a bill print out listing your services and your normal fees. This bill should show a zero balance. **Complete all applicable areas of this form and mail it to: Give Back a Smile, 402 West Wilson Street, Madison, WI 53703 or fax to 608.222.9540.**

Date of Case Completion: _____

Patient's Name: _____ Authorization Code: _____

Dentist's Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Before and After Photographs Enclosed:
Yes ☐ No ☐

Value of Donated Services:

Office Visit $ _____

Laboratory Donation: **$** _____

Specialists: $ _____

Miscellaneous Services: $ _____

Total Value: $ _____

Dental Laboratory Used: _____ Laboratory Work Donated? Yes ☐ No ☐

Number of Units Donated: _____

Contact Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Specialist Used: _____ Work Donated? Yes ☐ No ☐

Type of Specialist: _____

Address: _____ City: _____ State: _____ Zip: _____

Are you willing to treat another GBAS patient at this time? Yes ☐ No ☐

Additional program comments or comments regarding your GBAS patient experience: _____

_____

_____

Thank you for helping to restore a life!

GBAS Case Funding Disbursement Protocol

1. This is a volunteer program. Please ask your specialists and your laboratories to donate all services. No approval is needed from GBAS for your mutually agreed upon treatment plan. If this is not possible, and additional funds are needed to subsidize any procedures that **cannot be donated, prior approval is mandatory and protocol must be followed. All requests for funding and the subsequent documentation must be submitted and approved prior to the start of any dental treatment**.

The forms necessary for funding approval are enclosed and must be faxed to 608.222.9540 or e-mailed to givebackasmile@aacd.com

The protocol is:

1. AACDCF staff can approve up to $500 per case without the approval of the GBAS Committee.

2. If reimbursement requests exceed $500, the GBAS Committee will assess your request on an individual basis after reviewing documentation and funds availability.

3. The following documentation is required to support the funding request:

A) Photos displaying the area of necessary treatment. (E-mail to givebackasmile@aacd.com or mail to 402 West Wilson, Madison, WI 53703)

B) X-rays of the involved treatment area, FMX or Panoramic preferred. (E-mail to givebackamsile@aacd.com or mail to 402 West Wilson St, Madison, WI 53703)

C) A full case treatment plan provided by you, i.e. tooth number and needed restoration on every tooth diagnosed. (Page 7)

D) The laboratory fee for each tooth diagnosed. (Page 7)

E) The specialist fee for each tooth diagnosed. (Page 7)

F) The implant parts for each tooth diagnosed. (Page 7)

G) An itemized list describing cost for each procedure for which you request funding. (Page 7)

H) The request for funds sheet is attached to this packet. (Pages 7)

I) The GBAS Committee will review each case individually and decide what funds will be dispersed.

GBAS Treatment Plan/Funding Request

This form is confidential between the GBAS office and treating dentist. Requests are reviewed on an individual basis after reviewing documentation and funds availability.

Dentist's Name:_____ GBAS Patient Authorization Code:_____

Dentist's Phone Number:_____ Date:_____

Example of Funding Request

Tooth #	Procedure Needed	Specialist/Laboratory Services or Implant Parts	Funding Request
i.e.: 7	Crown	laboratory support	$100
i.e.: 8	Implant	periodontist fee	$300
i.e.: 9	Implant	parts needed	$500

Your Funding Request Treatment Plan (Portion for which you are request funds)

Tooth #	Procedure Needed	Specialist/Laboratory Service or Implant Parts	Funding Request
			Total:

Your Donated Treatment Plan (Portion for which you are *not* requesting funds)

Tooth #	Procedure Needed	Services Provided by You

Please fax to GBAS at 608.222.9540