

IMPORTANT: This template document is intended to assist Minnesota licensed dentists and dental hygienists who wish to enter into a collaborative agreement to meet the needs of Minnesota children enrolled in Head Start programs. It should be modified as needed to meet individual practice situations, and can be used for populations other than Head Start children. The Minnesota Dental Association believes that this document meets the statutory collaborative agreement requirements of Minn. Stat. §150A.10, subd. 1a; however, the parties should consult with their own attorneys to answer specific questions and address concerns before entering into any collaborative agreement.

Minnesota Community Collaborative Practice Agreement

Agreement Between:

DENTIST'S Name: _____

Work Address: _____

Work Phone: _____ Work Fax: _____

E-Mail: _____ MN Dental License #: _____

I, _____, DDS agree to serve as a collaborating dentist to _____, RDH for the **HEAD START PROGRAM ENROLLEES** wishing to receive dental hygiene services. I will accept patients only on an individual case by case basis. I further agree to abide by Minnesota Statute 150A.10, Subd. 1a and related Board of Dentistry Rules, Chapter 3100.

DENTIST SIGNATURE: _____ **DATE:** _____

DENTAL HYGIENIST'S Name: _____

Home Address: _____

Home Phone: _____ Fax: _____

E-Mail: _____ MN Dental Hygiene License #: _____

I, _____ hereby certify that I have been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including at least 200 hours of clinical practice in 2 of the last 3 years.

I further certify that I have documentation of participation in continuing education courses for my CURRENT license renewal cycle in Infection Control and Medical Emergencies, and that I maintain current certification in Advanced or Basic CPR.

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I, _____, RDH, agree to serve as a Collaborative Dental Hygienist with _____, DDS and agree to follow the attached protocols pertaining to my dental hygiene services rendered to HEAD START ENROLLEES. I agree to abide by Minnesota Statute 150A.10, Subd.1a and related Board of Dentistry Rules, Chapter 3100.

[I further agree that I will acquire and maintain individual professional liability/malpractice insurance covering both the location where services are provided and the specific dental hygiene services authorized under this Agreement. NOTE: Such coverage is not mandated by law, but it may be wise for both the dentist and the dental hygienist to have, particularly when the hygienist is not an employee of the dentist.]

DENTAL HYGIENIST SIGNATURE: _____ **DATE:** _____

Location(s) Where Community Collaborative Dental Hygiene Services Will Be Provided Under This Agreement:

For the purposes of this Agreement, pursuant to Minn. Stat. 150A.10, Subd. 1a., "a 'health care facility, program, or nonprofit organization' is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled or juveniles; state operated facility licensed by the commissioner of corrections; and federal, state, or local public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients."

Type of Facility/Program Where Services Will Be Provided: (Check one)

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> Hospital | <input checked="" type="checkbox"/> Head Start Program | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Home Health Agency |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> State Operated Facility | <input type="checkbox"/> Community Clinic | <input type="checkbox"/> Tribal Clinic |
| <input type="checkbox"/> School | <input type="checkbox"/> Nonprofit Organization | | |

Name Of Facility/Program: _____

Phone: _____ Fax: _____

Name of Program Contact Person: _____

Attach a list of addresses where dental hygiene services will be provided.

If the listed addresses of the facilities where services will be provided should change, or if the dental hygienist should find the need to provide services at an additional location, the hygienist shall immediately give written notification of the proposed change to the collaborating dentist and such change, if agreed to in writing by the collaborating dentist, shall become an Addendum to this Agreement.

Dental Hygiene Services Provided

Pursuant to Minnesota Statute 150A.10, Subd 1a., a dental hygienist may perform dental hygiene services without the patient (HEAD START ENROLLEE) first being examined by a dentist, if specifications in that statute have been met. For the purposes of this Agreement, the dental hygienist named in this Agreement shall provide assessment, triage and referral as outlined in the American Association of State and Territorial Dental Directors' "Basic Screening Survey." In addition, the dental hygienist may perform additional dental hygiene services as permitted under Minnesota Statute 150A.10, Subd. 1a., with statutorily required protocols attached to this Agreement. **[NOTE: Dentists and dental hygienists who use this Agreement form need to write their own protocols regarding dental hygiene services to be provided.]**

IMPORTANT: The dental hygienist named in this agreement should have completed a calibration

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exercise sufficient to perform the ASTDD "Basic Screening Survey," in accordance with the expectations of federal and state officials who approved this method of providing assessment, triage and referral of MINNESOTA HEAD START ENROLLEES.

I, _____, RDH, have completed the calibration exercise on _____ (DATE), at _____ (LOCATION).

Dentist Referrals

Patients receiving dental hygiene services under this Agreement must be referred to a Minnesota licensed dentist according to the following assessment/screening results, and must provide a copy of the referral form to the collaborating dentist:

1. Children showing no signs of treated or untreated caries and/or other areas of concern to be examined by a dentist within the next _____.
2. Children showing signs of untreated caries and/or areas of concern to be treated by a dentist within an appropriate length of time.
3. Children showing signs of untreated caries, pain, swelling and/or areas of urgent concern to be treated by a dentist as soon as possible.

Dental Records

Specify the procedure for creating and maintaining dental records for the HEAD START ENROLLEES who receive dental hygiene services under this agreement. _____

Location of Dental Records: _____

Consent To Treatment Form

The dental record for every HEAD START ENROLLEE who receives dental hygiene services by the dental hygienist named in this Agreement shall include a signed "Consent To Treatment" form, an example of which must be attached to this Agreement.

Considerations For Medically Compromised Patients

The collaborative practice dental hygienist named in this Agreement shall review individual patient medical history through facility/program and patient records and consult with the collaborating dentist or on-site medical personnel. When indicated by the patient's condition, dental or medical consultation **must** occur prior to the provision of dental hygiene services.

Annual Agreement Review

At least once a year or upon change, this Agreement must be reviewed and signed by the collaborating dentist and dental hygienist named in this Agreement. Copies of the original and updated agreements must be maintained by the dentist, the dental hygienist and the Head Start contact person named in this Agreement.