Parent/Guardian of

Ontario Ministry of Health

# Healthy Smiles Ontario

## Parent Notification Form Instructions
## Preventive Services Only Stream
## (HSO-PSO)

| |
|---|
| Please return this form to: |
| Public Health Unit: |
| Address: |
| Phone: Fax: |
| Client's School: |
| Date of Issue: |

| Public Health Unit (PHU) Use Only |
|---|
| Client's Name: |
| Screening date: |
| Screening Location: |
| By: |
| Date Received: |

Dear Parent/Guardian of _____

Your child had a dental screening and we encourage you to contact a dental provider for preventive services. Based on the results of your child's dental screening, your child is clinically eligible for the Preventive Services Only Stream of the Healthy Smiles Ontario program. If you would like more details, please contact the public health unit listed above.

Healthy Smiles Ontario – Preventive Services Only Stream (HSO-PSO) provides free preventive oral health services for up to 12 months for children who qualify. Preventive services may include cleaning, fluoride and sealants (a clear plastic coating on the biting surfaces of back teeth to prevent dental decay/cavities).

Your child is eligible if they:

- Are 17 years of age or under;
- Live in Ontario;
- Meet the financial eligibility criteria (Section 1); and
- Meet the clinical eligibility requirements as described in the *Oral Health Protocol, 2021* which can be found here: https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Oral% Protocols are published by the Minister of Health as per Section 7 of the *Health Protection and Promotion Act*.

**Please note:** Children 17 years old and under are automatically enrolled in Healthy Smiles Ontario and eligible for dental services when they or their household receive(s) Ontario Works, Temporary Care Assistance, Ontario Disability Support Program, or Assistance for Children with Severe Disabilities.

**To enroll a child or youth for preventive services:**

**Complete Section 1 OR 2 depending on the following:**

- Complete all sections and sign this Preventive Services Only Stream Parent Notification Form.
- Mail or drop off your completed form to your public health unit at the address listed above.
- You will receive a response once your form has been processed.

For more information or if you need help completing this form, please contact the Public Health Unit at the top of this page.

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Please return this form to:

Public Health Unit:

Address:

Phone: Fax:

Public Health Unit (PHU) Use Only

Client's Name:

## Section 1 – Financial Eligibility

**Please answer the questions below.**

1. Is your household income at a level where you could receive the Ontario Child Benefit? If you are not sure, please contact your local public health unit. ☐Yes ☐No

2. If you paid for the Preventive services, would your household suffer financial hardship resulting in any one of the following:

   a) Inability to pay rent/mortgage;

   b) Inability to pay household bills;

   c) Inability to buy groceries for the family; or

   d) The child/youth or family will be required to seek help from a food bank in order to provide food. ☐Yes ☐No

**If you answered NO to any ONE of the questions:**

You **do not** meet the financial eligibility requirements for the Preventive Services Only Stream of Healthy Smiles Ontario. Please consider taking your child to a dental provider for preventive dental services.

**If you answered YES to BOTH questions:**

You meet the financial eligibility requirements for the Preventive Services Only Stream of Healthy Smiles Ontario. Please complete Sections 2, 3, and 4 and mail or drop off your completed form to your public health unit at the address listed above.

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Please return this form to:

Public Health Unit:

Address:

Phone: Fax:

Public Health Unit (PHU) Use Only

Client's Name:

## Section 2 – Applicant Information

Applicant is the: (choose one)

☐ Custodial Parent

☐ Legal Guardian

☐ Youth – completing for yourself

Last Name

First Name | Middle Name (if applicable)

Telephone Number

**Residential Address**

Unit Number | Street Number | Street Name

City/Town | Province | Postal Code

**Mailing Address** ☐ Indicate (√) if same as Residential Address

Unit Number | Street Number | Street Name

City/Town | Province | Postal Code

## Section 3 – Client Information (Child/Youth)

Last Name

First Name | Middle Name (if applicable)

Date of Birth (yyyy/mm/dd) | Sex ☐ Male ☐ Female ☐ Other

School (if applicable)

Ontario Ministry of Health

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## Preventive Services Only Stream (HSO-PSO)

Please return this form to:

Public Health Unit:

Address:

Phone: Fax:

Public Health Unit (PHU) Use Only

Client's Name:

## Section 4 – Terms and Conditions and Consent

**I declare that:**

- The client for whom this Healthy Smiles Ontario Preventive Services Only Stream (HSO-PSO) Application is being completed meets the eligibility requirements for the HSO-PSO;
- I have not misrepresented information about the client, myself or my household and understand that any misrepresentation may result in the immediate removal of the client from HSO-PSO, and that the Government of Ontario may seek reimbursement for any services that were rendered while the client was ineligible for the program;
- I understand that the information on this application may be subject to audit and verification and that I must immediately report any changes that may affect the eligibility of the client to the Ministry of Health;
- I understand that the mailing address given on Section 2 of this Application form will be the mailing address used for the client listed;
- I understand that only certain dental procedures are covered under HSO-PSO, I am responsible for paying for services not covered or paid for under HSO-PSO;
- I understand that the client's eligibility for preventive services under HSO-PSO is up to 12 months starting from the registration date and will expire either at the end of the 12 month period or the 18th birthday of the client listed, whichever date is earlier;
- I consent to the collection, use and disclosure of any of the information included on this form or submitted in connection with this form by and among my dental services providers(s), the relevant board of health (public health unit) and the Ministry of Health (MOH); and
- I also consent to the collection use and disclosure of related treatment information among my dental service provider(s), the relevant board of health and the MOH for the purpose of follow-up, case management, program administration and reporting, and evaluation.

X Signature of Parent/Guardian/Youth

Date (yyyy/mm/dd)

**The completed form must be mailed, faxed or delivered to the public health unit at the address at the top of this page within 20 business days.**