Smart Mouths Smart Kids Data Collection Tool

User Application

The following information is required to authorize access to the Smart Mouths Smart Kids (SMSK) data collection tool. All users of the system must complete an application.

The state Oral Health Program will review the data you submit and will also access your license records (if applicable) at the Department of Regulatory Agencies to conduct a background check.

First Name: _____ Last Name: _____

Email address: _____

What is your primary profession? (Please check all that apply)

- Dentist (DDS, DMD) _____
- Registered Dental Hygienist _____
- Dental Assistant _____
- Dental Office Manager _____
- Other, please list _____

Primary Type of Practice Setting:

- Private Dental Office _____
- Independent Hygienist/Practice _____
- Local Public Health Agency _____
- Federally Qualified Health Clinic _____
- Rural Health Center _____
- Other, please list _____

Practice/Organization Name: _____

Address: _____ City: _____ Zip Code: _____

Phone Number: _____

Professional License Number: _____

When participating in this program, we strongly encourage you to prioritize oral health prevention services for children who attend schools with greater than 50 percent free and reduced lunch (FRL) enrollment. This recommendation ensures that limited resources are used caring for children with higher risk of oral disease. *The Oral Health Program can provide a list of schools that meet the need criteria or you can access that information at the Colorado Department of Education website.*

When participating in Smart Mouths Smart Kids, do you agree to see all children regardless of their ability to pay? Yes____ No ____

Please refer to the following link for more details on how to manage payment for uninsured and publicly insured children: *http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf*

What school district(s) do you plan to deliver services (please list)? _____

_____

What grades do you plan to provide services? (Check all that apply)

Head Start ____

Pre-School ____

Elementary (K-5th) ____

Middle School/Junior High (6th-8th) ____

High School (9th-12th) ____

Other, please explain _____

What services do you plan to provide?

Prophylaxis ___

Fluoride Varnish ___

Sealants ___

Screenings ___

Other, please list _____

Data Use Agreement

This Data Use Agreement (Agreement) is between the Colorado Department of Public Health and Environment (CDPHE), Oral Health Program (Data Owner) and
_____ (Data User).
[enter your program name]

Data Owner Obligations:

The Data Owner, agrees to provide the following information to the Data User either in the format indicated in the application.

Data User Obligations:

a. *Uses and Disclosures as Requested in this Agreement*. The Data User shall use and disclose the confidential information provided by Data Owner only for the activity described in the application. The Data User shall limit access to confidential information strictly to those individuals or classes of individuals who shall have access in order to perform the duties set forth in the application.
b. *Nondisclosure Except as Provided in this Agreement*. The Data User shall not use or further disclose the confidential data except as specified in this Agreement.
c. *Safeguards*. The Data User agrees to take appropriate administrative, technical and physical safeguards to protect the data from any unauthorized use or disclosure not provided for in this Agreement. The Data Owner shall ensure that no identifying information is transmitted through unsecured telecommunications, including unsecured Internet connections.
d. *Confidentiality Agreements*. The Data User shall ensure that all persons who have access to the confidential information sign the Confidentiality Agreement (page 4). This includes, but is not limited to, all interns, sub-contractors, staff, other workforce members and consultants. A copy of the signed Data Use and Confidentiality Agreement shall be maintained on file and be available for review by the Data Owner, if requested.
e. *Reporting*. Within 48 hours of the Data User's discovery, the Data User shall report to the Data Owner any use or disclosure of the confidential information that violates either this Agreement or applicable state or federal laws or regulations.
f. *Public Release*. No confidential information shall be publicly released.
g. *Minimum Necessary*. The Data User attests that the confidential information requested represents the minimum information necessary for the Data User to perform duties described in the application and that only the minimum necessary individuals shall have access to the confidential information in order to perform such work.
h. *Authorizations*. The Data User agrees to obtain individual authorizations to the confidential information if the activity entails research. Documentation shall be provided prior to receipt of the confidential information.
i. *Data Ownership*. The Data Owner is the Oral Health Program. The Data User does not obtain any right, title or interest in any of the data furnished by the Data Owner.
j. *Publication/Release Requirements*. The Data User shall not release or publish any data from the system without the advance, express, written permission of the Data Owner.

Data Security, Use and Confidentiality Agreement

Issuance of a user account and access to this system is predicated upon the acknowledgement, acceptance and adherence to the terms set forth below.

Data User understands and agrees to all of the following:

- Anything the Data User may access, create, store, send or retrieve within the SMSK network will be accessible by staff at CDPHE.
- Data ownership of the content of SMSK is assigned to CDPHE, including any data that you enter into the system.
- By signing this Agreement, Data User waives any rights to the data, and your consent to monitoring, retrieval and disclosure of any information Data User provides in this network, for all purposes deemed appropriate by CDPHE, including the enforcement of agency rules. Data User's employer is responsible for completing and storage of criminal back ground checks for each data user.

Data User shall not copy or discuss confidential information and/or reports with family members, friends, professional colleagues, other employees, clients/customers, or any other person unless such person has been authorized to access that information. If Data User is unsure who is authorized to access the information in the SMSK system, Data User will check with their point of contact responsible for the information.

- Any violation of federal or state law or this Agreement will be considered a breach of obligations and may result in disciplinary action, including termination of contractual relationship and other remedies allowed by law.

- Data User is responsible for the secure handling of sensitive personnel, financial and/or security related information that Data User is authorized to handle. Transmission of material in violation of any state or federal law or regulation is prohibited.

- Each account holder is assigned a unique username and password to access the network, systems and/or applications. Users shall not share passwords with any other individual and each user assumes full responsibility for the security of his/her password.

- Data User will access only information needed to perform the job and not access or attempt to access unauthorized files. Data User shall not "browse" or otherwise use files or programs that exceed what is the minimum job necessary. The use and disclosure of information will be consistent with those permitted by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable laws and rules.

- Attempts to defeat security mechanisms are treated as a security incident and are potentially subject to civil and/or criminal penalties. Data User should report to Data Owner any observed attempts by others to defeat security mechanisms.

If this form is incomplete or unclear, it may cause delays with processing this request. The Oral Health Program will make every effort to process your request within five business days after receiving a completed form. Please email or fax a completed and signed application to the following: breezie.mitchell@state or 303-692-2529.

Data User Signature: _____ Date: _____