Sample Collaborative Arrangement Agreement Form

A collaborative arrangement is an agreement between a New York State (NYS) registered dental hygienist working for a hospital, as defined in Public Health Law §2801, and a NYS licensed and registered dentist who has a formal relationship with the same hospital. This is a sample collaborative arrangement written agreement that includes recommended best practices information. Please note that you are not required to submit it to the New York State Education Department.

**Dental Hygienist Information:**

Name and Title:
Address:
Phone Home:
Work Phone:
Cell Number:
Email:
New York Dental Hygiene License Number:

**Collaborative Practice Dentist Information:**

Name and Title:
Address:
Phone Home:
Work Phone:
Cell Number:
Email:
New York Dentist License Number:

Please provide information regarding practice location(s) for the oral health care program and point of contact.

1(a). Name and address of Article 28 facility site (as defined in Article 28 of the Public Health Law 2801):

1(b). Name, title and credentials of the person authorized to represent the facility site (include address if different from above):

2(a). Name and address of Article 28 facility site (as defined in Article 28 of the Public Health Law 2801):

2(b). Name, title and credentials of the person authorized to represent the facility site (include address if different from above):
List of all approved procedures (to be completed by collaborating Dental Hygienist and Dentist).

- **Dental Hygienist** Please check all procedures (below) that you request to perform under the General Supervision. Pursuant to Education Law §6606 and Commissioners Regulations §61.9(b) all other procedures not listed below must be performed under Personal Supervision of a dentist.

- **Dentist** Please check all procedures that you approve to be performed under the General Supervision based on the collaborating Dental Hygienist’s experience, competence and qualifications.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Hygienist Procedures</th>
<th>Dentist Approval</th>
<th>Dentist Initials</th>
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</thead>
<tbody>
<tr>
<td>Complete prophylaxis, and scaling and planning of exposed root surfaces</td>
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<td>Applying topical agents indicated for a complete prophylaxis</td>
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<tr>
<td>Removing excess cement from tooth surfaces.</td>
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<tr>
<td>Providing patient education and counseling to improve oral health</td>
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<td>Taking and exposing dental radiographs</td>
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<td>Providing topical anticarcinogenic agents, including but not limited to topical fluoride applications, and performing topical anesthetic applications</td>
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<td>Polishing teeth, including existing restorations</td>
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<td>Taking and assessing medical history including the measuring and recording of vital signs as an aid to diagnosis by the dentist and to assist the dental hygienist in providing dental hygiene services</td>
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<tr>
<td>Performing dental and/or periodontal assessments as an aid to diagnosis by the dentist and to assist the hygienist in providing dental hygiene services</td>
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<tr>
<td>Applying pit and fissure sealants</td>
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<td>Applying desensitizing agents to the teeth</td>
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<td>Placing and removing temporary restorations</td>
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<td>Making assessments of the oral and maxillofacial area as an aid to diagnosis by the dentist</td>
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<td>Taking impressions for study casts, which will be used only for purposes of diagnosis and treatment planning by the dentist and for the purposes of patient education</td>
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<td>Providing dental health case management and care coordination services which must include but not be limited to:</td>
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<td>1)Community outreach</td>
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<td>2)Improving oral health outcomes</td>
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<td>3)Improving access to dental care by assisting people in establishing an ongoing relationship with a dentist, in order to promote the comprehensive, continuous and coordinated delivery of all aspects of oral health care</td>
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<td>4)Assisting people to obtain dental care</td>
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</table>
Please ensure that the following items are in place and check each item below accordingly.

___ A list of licensed providers available for emergency absences of either the Dental Hygienist or Collaborating Dentist.

___ A plan for the Collaborating Dentist to periodically review the patient records (e.g., every 6 months?).

___ A protocol to assure security of hard-copy/paper patient records, if applicable.

___ A protocol to ensure effective case management and care coordination, including treatment and consultation, if necessary.

___ A protocol for any other provisions as determined by the Dental Hygienist and the collaborating Dentist to be appropriate.

___ Current cardiopulmonary resuscitation certification for the health care provider (Dental Hygienist) is on file.

___ A policy for professional liability insurance coverage is in place.

This written agreement will be held at the following location (Article 28 facility):

Signature of Dental Hygienist entering the Collaborative Arrangement:
________________________________________________________________________
Date: __________________________

Signature of Dentist entering the Collaborative Arrangement:
________________________________________________________________________
Date: __________________________

Collaborative arrangement start date:

Annual renewal/review occurred on:
1)
2)
3)

Dental Hygienist signature: ______________________________________________________
Date: _________________________________________

Dentist signature: ______________________________________________________________
Date: _________________________________________