

HEALTH SERVICES AGENCY  
ADMINISTRATION

# COUNTY OF SANTA CRUZ

## HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE  
SANTA CRUZ, CA 95061  
(408) 454-4066 FAX: (408) 454-4770  
TDD: (408) 454-4123

May 4, 1999

AGENDA: May 18, 1999

BOARD OF SUPERVISORS  
County of Santa Cruz  
701 Ocean Street  
Santa Cruz, CA 95061

Re: APPROVAL OF 1999-2000 DENTAL DISEASE PREVENTION PROGRAM FUNDING APPLICATION

Dear Board Members:

The Health Services Agency is requesting approval of the attached 1999/00 renewal funding application for the Dental Disease Prevention Program. The \$22,973 application, which was due to the State on April 16, 1999, was submitted subject to your Board's approval. Also attached is a State-required resolution approving the application and authorizing the Health Services Agency Administrator to sign the related State revenue agreement when received.

Each year, the Health Services Agency receives State funding for various school-based dental disease prevention activities called the "Happy Tooth" program. This program provides supervised brushing and flossing in the classroom, instructional visits by a trained dental health instructor, educational materials and supplies, and teacher training workshops for participating schools.

The program is designed to reach 5,105 pre-school and elementary school children in high need areas in the County and to stimulate the development of community resources to respond to the need for preventive oral health services for children. The State funds support a part-time bilingual Health Program Specialist to coordinate the program and to conduct class visits. Supplies and materials are underwritten by the County.

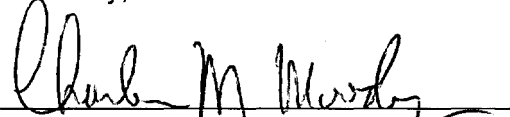
It is therefore RECOMMENDED that your Board:

1. Adopt the attached resolution approving the \$22,973 funding application for the 1999-00 Dental Disease Prevention Program and authorizing the Health Services Agency Administrator to sign the related State revenue agreement when received, and

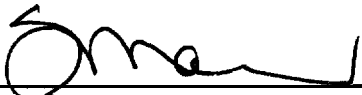
2. Direct the Clerk of the Board to return one certified copy of the resolution to the Health Services Agency to forward to the State.

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Sincerely,

  
Charles M. Moody, HSA Administrator

RECOMMENDED:

  
Susan A. Mauriello  
County Administrative Officer

cc: County Administrative Office  
Auditor-Controller  
County Counsel  
HSA Administration

Resolution No. \_\_\_\_\_

On the motion of Supervisor  
duly seconded by Supervisor  
the following resolution is adopted:

**RESOLUTION APPROVING FUNDING APPLICATION FOR THE DENTAL DISEASE PREVENTION PROGRAM AND AUTHORIZING SIGNATURE OF THE RELATED STATE STANDARD AGREEMENT**

WHEREAS, the State Department of Health Services has solicited funding applications for the 1999-00 Dental Disease Prevention Program; and

WHEREAS, the funding application requires a Resolution from the Local Governing Body authorizing the application submission and further authorizing the local Agency Administrator to sign the resultant State Standard Agreement and any amendments thereto related to minor program changes; and

WHEREAS, the Health Services Agency has prepared a funding application for the 1999-00 Dental Disease Prevention Program in the amount of \$22, 973.

NOW, THEREFORE, BE IT RESOLVED that the Santa Cruz County Board of Supervisors hereby approves the 1999-00 funding application for the Dental Disease Prevention Program in the amount of \$22,973 for the period July 1, 1999 - June 30, 2000 and authorizes the Health Services Agency Administrator to sign the related State Standard Agreement and any amendments thereto related to minor program changes.

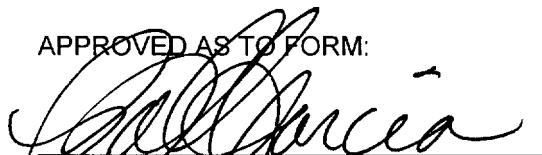
PASSED AND ADOPTED by the Board of Supervisors of the County of Santa Cruz, State of California, this   o   day   f  , 1999, by the following vote (requires four-fifths approval).

AYES:           Supervisors  
NOES:           Supervisors  
ABSENT:        Supervisors .

\_\_\_\_\_  
Chair of said Board

ATTEST: \_\_\_\_\_  
Clerk of Said Board

APPROVED AS TO FORM:

  
\_\_\_\_\_  
Assistant County Counsel

Distribution:

- County Administrative Office
- Auditor-Controller
- County Counsel
- HSA Administration

APPLICATION COVER/INFORMATION SHEET  
FY 1999-2000

i. contact Person for this Application and Mailing Address

Legal Name of Agency Santa Cruz County Health Fed Tax I.D.# 95-6000534

Title of Project "Happy Tooth" - Dental Disease Prevention Program

Mailing Address P.O. Box 962

City Santa Cruz ZIP 95060 County Santa Cruz

Contact Person's Name Yolanda Chavez Phone (831) 454-4312

Project Coordinator's Name Celia Barry Phone (831) 454-4318

Mailing Address P.O. Box 962

2. Proposed Funding Amount \$ 22,973

3. Proposed Number of children to be served:

PRE-K	K	1	2	3	4	5	6	UNGR	TOTAL
1,232	816	862	752	548	493	202	156	44	5,105

4. The undersigned hereby affirms that the statements contained in this application package are true and complete to the best of the applicant's knowledge, and accepts as a condition of any resulting contract the obligation to amply with applicable state requirements, policies, standards, and regulations. The undersigned recognizes that this is a public document and open to public inspection.

Signature  Date 3/1/99

Type Name and Title Celia Barry, MPH Senior Health Educator

## Attachment III

CERTIFICATION OF COMPLIANCE  
DENTAL DISEASE PREVENTION PROGRAM  
FOR THE PERIOD 7/1/1999-6/30/2000

1. I certify that the average percent of students on the Federal Free and Reduced School Lunch Program (FSLP) in schools served by the Program is at least equal to or greater than the percent of children on the FSLP in all public schools in the county as determined by the attached 1996-97 FSLP data. Note: any new schools added must equal or exceed the above-mentioned ratio.
2. I certify that the Program will comply with the following four mandatory program components: a) an approved fluoride application in suboptimally fluoridated communities; b) plaque control; c) classroom oral health education; and d) an oral health advisory committee with proper representation including education, the dental professions, and parent groups. In addition the preschool program will have a parental involvement component. I intend ( ) do not intend () to offer a dental sealant component. If a dental sealant component is included, I will comply with the sealant guidelines promulgated by the Office of Oral Health.
3. I certify that the Program will comply with the Fluoride Guidelines (including parental consent) which were attached to this modified RFA and received by me. Attached to this application is the current fluoride prescription for the Program. Note: Programs that have an approved fluoride component in place do not need to resubmit an Application for Program Approval: 1) if the Program does not intend to make any change to this component; and 2) if new schools are added in an already participating district and the water sources are the same. However, applications must be submitted if new schools in new districts are to have a fluoride component. In this case, submit: a) letters of approval from new districts and/or from new schools within a participating district, whichever is applicable; b) fluoride water levels of both the new schools and communities involved; c) fluoride prescriptions; d) fluoride dosage intended for each new school; e) sample of parent consent form. If continuing schools are making a change from fluoride mouthrinse to supplements, submit b, c, d, and e above.
4. I certify that the Scope of Work for FY 99/2000 is the same as for FY 98/99 with the exception of new dates to reflect the new Fiscal Year.

or

The Scope of Work for FY 99/2000 has been revised and is attached.


- 5. I certify that the Evaluation for FY 99/2000 is the same as for FY 98/99 with the exception of new dates to reflect the new Fiscal Year.

or

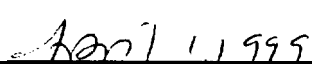
The Evaluation has been revised for FY 99/2000 and is attached.

- 6. Attached is a copy of the DDPP Line Item Budget for FY 99/2000. (Note: when computing the budget, please use the same total dollar amount you received for FY 98/99 unless you intend to decrease your budget in which case use that lower amount as your budget total).

- 7. I certify that the attached Budget Summary is the best estimate of total Program costs by funding source for FY 99/2000.

Signature   
 \_\_\_\_\_  
 CELIA BARRY

Printed Name of Authorized Representative

  
 \_\_\_\_\_  
 Date

Legal Name of Program Santa Cruz County Health Services Agency

BUDGET  
DDPP Line Item Budget

Contractor: Santa Cruz County Health Services Proposed State Funding \$ Amt \$22,973

1.	Personal Services(include positions & rate x time calculations)	
1.	Health Program Specialist, Bilingual (1,357/biweekly X .60 FTE X 26 pay periods) [applicant is contributing balance]	\$21,169
2.	Fringe Benefits @ Actual	\$1,804
3.	Indirect Costs (@ % of Personal Services) (@ % of Contractual Services)	
4.	General Expense	
5.	Expendable Supplies	
6.	Printing & Duplicating	
7.	Communications & Postage	
8.	Travel, Per Diem & Training	
9.	Contractual Services	
10.	Educational Services	
11.	Rent & Utilities	
12.	Other (Specify)	
	TOTAL	\$22,973

## BUDGET SUMMARY

BUDGET CATEGORY	PROPOSED SOURCES OF FUNDING				
	State	Applicant	In-Kind	Other	TOTAL
A. Total Salaries	\$ 21,169	\$ 1,731			\$ 22,900
B. Fringe Benefits	\$ 1,804	\$ 5,754			\$ 7,558
<b>TOTAL PERSONAL SERVICES</b>	<b>\$ 22,973</b>	<b>\$ 7,485</b>			<b>\$ 30,458</b>
C. INDIRECT COSTS		\$ 7,615			\$ 7,615
D. General Expense		\$ 200			\$ 200
E. Expendable Supplies		\$ 3,500			\$ 3,500
F. Printing & Duplicating		\$ 200			\$ 200
G. Communications & Postage					
H. Travel, Per Diem & Trainina		\$ 450			\$ 450
I. Contractual Services					
J. Education Materials		\$ 100			\$ 100
K. Rent & Utilities					
L. Other					
<b>TOTAL OPERATING EXPENSES</b>		<b>\$ 4,450</b>			<b>\$ 4,450</b>
<b>TOTAL</b>	<b>\$ 22,973</b>	<b>\$ 19,550</b>			<b>\$ 42,523</b>



**Board of Supervisor's Resolution Supporting  
Application Submission**

**Forthcoming May 25, 1999**