

FLORIDA HEIKEN CHILDREN'S VISION PROGRAM
Statewide Vision Program

601 Southwest 8th Avenue

Miami, FL 33130

Phone: (305) 856-9830 / 1(888) 996-9847 Fax: (305) 856-9840 / 1(888) 980-8474

WWW.MIAMILIGHTHOUSE.ORG/FLORIDAHEIKENPROGRAM.ASP

OFFICE/ EXAM
OPTOMETRIST MANUAL

2011-2012 School Year

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Dear Doctor,

Thank you for your interest in becoming part of the Florida Heiken Children's Vision Program! Our organization strives to bring excellent eye care to the financially disadvantaged students in the Florida State Public School system in your county.

Enclosed is our Optometric Provider Manual, describing the policies of our program. Please read this carefully, and once you have agreed to all the terms, fill out and sign the application on the last page and fax it back to our office along with the additional documents. We look forward to working with you, and greatly appreciate the services you offer the community!

Sincerely,

The Florida Heiken Team

Mission Statement

The mission of the Florida Heiken Children's Vision Program (FHCVP) is to provide comprehensive eye health/vision exams and eyeglasses to financially disadvantaged students enrolled and attending Florida Public Schools (FPS) in our contracted counties, at no cost to the student, parent or school.

Program Goals and Objectives

- To provide a Statewide Vision Program (SVP) and have accessible in-office optometric services for those students who have failed their school vision screening (as defined by a student having failed twice, performed by the school health program coordinator, school nurse and or his/her designee) and referred to local independent optometric physicians in network.
- To provide comprehensive eye exams (including dilated fundus exams, as pertains to Florida State Law Chapter 64B13-3 , Standards of Practice #64B13-3.010)
- To provide one pair of eyeglasses for those students found to need glasses at no cost to the student, family, or school.
- For the optometrist to take proper action to make health care referrals or in office treatment for binocular vision, or medical problems found during the eye exam.
- To implement an annual program evaluation to measure, assess and improve program performance and efficiency that will provide a basic structure to ensure continuous quality improvement.
- To implement a work plan with time frames for corrective actions to attain desired program outcomes.
- To assure that grant funds are being used efficiently.
- To maintain an excellent level of performance.
- To be in compliance with Florida state law and Section 504 of the Rehabilitation act of 1973

Credentialing

All independent optometrists applying to participate will be supplied with this Optometrists Procedure Manual that will outline all requirements and procedures regarding the program, in which all ODs are asked to provide:

- Signed FHCVP Independent Optometrist Application agreeing to all rules and procedures in Optometrists Procedure Manual
 - Curriculum Vitae
 - Copy of Optometry School Diploma
 - Copy of current Florida Optometry License
 - Proof of current malpractice insurance
 - Signed Attestation of good moral character
 - American Disabilities Act (Section 504) Compliance and Procedures Form

You will be asked to update your contact information yearly (Recredentialing) as well as complete a satisfaction survey for the program

Appointment scheduling

- Your office will receive a voucher with the student's contact information and brief medical history. The parent/guardian is also forwarded your office information. These vouchers are valid for 30 days after being sent to your office. After this time, the student's eligibility must be verified again
- Your office is asked to make a maximum of 5 attempts (on separate days) to contact the parent/guardian to schedule the appointment. If after 5 attempts, you are unable to contact the parent/guardian, please fax the voucher back to us
- If the student is a "no-show," cancels without rescheduling, or cannot be scheduled after 5 attempts, please fax the voucher back to our office
- Once Student is seen please give copy of Optometrist Report (Found on-line) to the parent/guardian and fax a copy to the Heiken Program Manager.
- All materials/forms can be found online at www.miamilighthouse.org/floridaheikenprogram.asp , then click on the Statewide Program on the upper right hand corner.

Payment for Services

- Billing for exam and glasses will be handled through iCare Options, a Third Party Administrator. Please contact FOPN for processes, Gisell Hernandez at 305-418-2025 Ext. 221 or 1-877-418-2025
- Please contact Cindy Vargas at 305-418-2025 Ext. 203 or 1-877-418-2025, to obtain a User ID and password.
- Reimbursement for services will be distributed on a monthly basis

Patient Care/Quality of Service

- All students' parent/guardian will be given a copy of their prescription and examination results, for which the student is to bring a copy to the school. We ask that you use the enclosed form for the prescription and results.
- No student/minor may be seen without a parent/guardian present at all times in the examination room
- If the student loses or breaks their glasses, there is a one-time 6 month warranty. After 6 months they may obtain a new pair for \$40 or you have the option to dispense a pair of equal quality frames and polycarbonate glasses from your dispensary at the same cost of \$40
- A copy of the Patient Rights and Responsibilities will be available for review at your office.
- All eligible patients must be given services, scheduling of appointments and accuracy of record keeping without regard to race, sex, color, national origin, religion, age or disability.

Patient Conflict Resolution

If a disgruntled student, parent, or school official presents to your office, you should do everything in your power to disengage the behavior of the individual. If assistance is needed, the program manager of the FHCVP-SVP should be contacted to resolve the problem.

- Any situations that arise should be reported directly to the FHCVP-SVP Program Manager

State and Federal Requirements for Abuse

- Any person who knows or has reasonable cause to suspect child abuse,

abandonment or neglect by a person responsible for a child's welfare is required to report that information to the state's toll free hotline, an appropriate law enforcement agency or (in the case of a child's death) medical examiner (FL Stat 39.201)

- Health professionals are among those specifically enumerated as required reporters under these laws. When reporting, such persons are required to provide their names (others may report anonymously).

- Note that there is an exception in the reporting provisions for health care professionals or other persons who provide medical or counseling services to pregnant children, when such reporting would interfere with the provision of medical services.

- State law also provides for confidentiality of such reports (30.202 and 415.107); immunity from liability for good-faith reporting, and a civil cause of action for anyone whose employment is adversely affected by that reporting (39.203 and 415.1036); abrogation of privileged communications, except between attorney and client (39.204 and 415.1045); civil, criminal misdemeanor and, in some circumstances, felony penalties for non-reporting or false-reporting (39.205, 206 and 415.1113).

- When reporting abuse/neglect/exploitation to the Florida Abuse Hotline the health care professional should be prepared to describe the following:

- Victim name, address or location, approximate age, race and sex
Signs or indications of harm or injury, including a physical description if possible

- Relationship of the alleged perpetrator to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.

Ways to make a report

Telephone: 1-800-96ABUSE

FAX: a written report with your name and contact phone and all the information above to 1-800 914-0004

State and Federal Requirements as to Title VI Section 504 and the Americans with

Disabilities Act

- Entrances, waiting rooms, reception areas, restrooms and other facilities must be equally available to all clients

- Have self evaluation practices every year to ensure no barriers to services and care and policies in place to care for those who are disabled, visually impaired, hearing impaired, mentally impaired, and or mobility impaired.

- Facilities with fewer than 15 employees, after consultation with a person with a disability seeking your services, determines there is no method of complying with accessibility requirements other than making significant alteration to its existing facilities, you must have in place a referral policy to the individual to another provider whose services are accessible.

- Facilities with more than 15 employees are required to provide appropriate auxiliary aids to persons with impaired sensory, manual or speaking skills when

necessary to benefit from your services (Auxiliary Aids may include Braille, taped materials, interpreters for the deaf and other such aids. Those with fewer than 15 employees are required to provide auxiliary aids when the provision of such aids does not significantly impair the ability of the provider to provide its benefits or services.

- If there are any questions about the above requirements please read the policies as outlined by the Florida Department of Health or Call the Heiken Program manager to resolve any issues.

Referral Information

HIPPA regulations will be adhered to in all cases

Because of the unique nature of our program, follow-up appointments are not covered, and it is up to the independent optometric physician to use their current protocol for referral to another optometrist or ophthalmologist if a student needs eye drops prescribed, medically necessary contact lenses, or other specialized care.

- If a student needs to see a specialist, the optometric physician is to make the proper referral (using their own in office protocols). Again this is not covered by the FHSVP.

In cases where the referral is considered an “Emergency” (i.e., sight or life threatening situation) the school and parent will be contacted immediately to set up an immediate referral with the appropriate specialist.

Product Liability

- All glasses orders will be placed through OptiLab at www.hcvp.org
- A frame selection kit will be sent to your office
- All eyeglasses will be made in polycarbonate material
- OptiLab will provide medically necessary tints at no cost, but their use must be specified on the order sheet and exam form “Medically Necessary Tint due to...” (i.e., retinitis pigmentosa, albinism etc.)

- FHCVP will not reimburse for any lens or frame upgrades. If the parent/guardian would like to upgrade, there is no credit provided. Any frame choice outside of the provided Heiken Kit selection will NOT have lenses provided for, and are considered a private job through your office.

- Contact lenses are considered a luxury that requires follow-up care and will not be provided by the FHSVP. If there is an indication for medically necessary contact lenses, you can fit the lens at your discretion, but please be aware that you will NOT be reimbursed for any costs associated with the materials or follow-up visits. If further follow-up care is required for contact lenses, all costs must be disclosed to the parent/guardian prior to scheduling the follow-ups.

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• PATIENT RIGHTS AND RESPONSIBILITIES

The physicians, employees, and staff who are involved in providing vision care services to you, sincerely believe in providing the highest quality of care and services available. We will always try to communicate with our patients, and to address their questions and concerns in a direct, informative way, while offering appropriate explanations and viable choices.

Patient Responsibilities

- Keep all appointments and, when unable to do so for any reason, promptly notify your eye care provider and facility involved
- Provide accurate, complete, and honest information about present vision problems, past illnesses, hospitalizations, medications, and other matters that relate to your eye care needs
- Treat your eye care provider/staff/facility with respect and consideration and conduct yourself with decorum.
- Be considerate of the rights of other patients in the facility and assist in controlling noise and/or other disruptions
- Be respectful of the property of other patients in the facility
- Report any unexpected changes in your condition
- Ask questions if you do not understand your treatment or what is expected of you
- Follow the treatment plan recommended by your eye care provider
- Patients will complete a satisfaction survey so as to help the FHSVP provide the best quality care

Patient Rights

- Receive available vision care services regardless of race, color, sex, national origin, religion, age or disabilities
- Always be treated with courtesy and respect, dignity and regard
- Know what benefits you are due and what your responsibilities are for those benefits
- Know who is providing your vision care services
- Expect reasonable confidence, comfort, and safety in your environment
- Receive full information concerning the evaluation of your vision care needs
- Receive Auxiliary Aids when needed
- Receive prompt answers to your questions and/or requests
- Refuse any treatment, except as otherwise provided by law
- Receive an explanation if there is a need for referral to another vision care provider or Medical care provider
- Report any complaints you may have about the quality of vision care you receive
- Request privacy information regarding your personal and vision care information within the normal guidelines of the law
- Have your records released to the professional person of your choice for any appropriate continuing care

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Optometrist Application

Name: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Office Contact Person: _____

SS# or EIN: _____ NPI# _____

Mailing address (if different): _____

Email: _____

Languages Spoken: _____

Race / Ethnicity (Circle One): Hispanic, African American, Haitian, American Indian, Asian, Caucasian , Other

Gender: Male / Female

If you need to be credentialed with FOPN please call Gisell Hernandez at 877-418-2025 ext221
Please fax the complete application and the following additional documents to the Florida Heiken Children's Vision Program Manager at (305) 856-9840/ 1(888) 980-8474 . If you have multiple doctors that work at your office and will be seeing our students, please provide the additional documents for them as well:

Current Florida Optometry License

Proof of current malpractice insurance

W-9 Form

Signed Attestation of Good Moral Character

Signed Equal Employment Opportunity Policy

Signed Americans with Disabilities Act and Fill out Questionnaire

I have received and read a copy of the Florida Heiken Children's Vision Program In-Office policies and procedures. By signing below, I agree to all terms and conditions herein.

Doctor Signature Date Signed

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Americans with Disabilities Act (ADA) Policy

The Heiken Childrens Vision Program is committed to complying with all applicable provisions of the Americans with Disabilities Act (ADA). It is the policy of the Heiken Program to ensure equal opportunity for qualified individuals with disabilities for those enrolled in its program. Qualifications to be a provider will be based on the applicants ability to perform the essential function of the job. The Heiken Program will not discriminate against otherwise-qualified applicants in any of its contracted activities.

The Heiken Program will provide any reasonable accommodations to qualified enrolled applicants with a disability, as defined by the ADA, who have made the Heiken Program aware of their disability, provided that the accommodation does not impose an undue hardship on the Heiken Program.

The Heiken Program is also committed to not discriminate against any applicant because a family member or friend is covered under the protection of the ADA. The Heiken Program will follow any state or local law that provides individuals with disabilities greater protection.

This policy is neither exhaustive nor exclusive. The Heiken Program is committed to taking all other actions necessary to ensure equal opportunity for persons with disabilities in accordance with the ADA and all other applicable federal, state and local laws.

Acknowledgement

I hereby certify that I have received a copy of the Heiken Program's ADA policy and that I have read, understand, and agree to abide by the provisions set forth in this policy.

Doctor Signature: _____

Doctor Printed Name: _____

Date: _____

Witness Signature _____

Printed Name _____

Date _____

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Equal Employment Opportunity Policy

It is the policy of the Heiken Program to provide equal rights to our providers based on qualifications (licensure, in compliance with state optometry practices and procedures, malpractice

insurance, of good moral character, disability and self evaluation protocols), job performance and abilities. The Heiken Program does not discriminate on the basis of race, color, religion, ancestry, national origin, gender, pregnancy, age, disability, marital status, sexual orientation or any other characteristic protected by applicable federal, state or local laws.

This policy governs all aspects of becoming part of the Heiken Program, but not limited to compensation, benefits, promotions, trainings, discipline and termination.

Contracted doctors with questions or concerns about any type of discrimination are encouraged to bring these issues to the attention of the Heiken Program Manager.

Acknowledgement

I hereby certify that I have received a copy of the Heiken Program's ADA policy and that I have read, understand, and agree to abide by the provisions set forth in this policy.

Doctor Signature: _____

Doctor Printed Name: _____

Date: _____

Witness Signature _____

Printed Name _____

Date _____

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Americans with Disabilities Act
Questionnaire

1- Does this facility meet ADA Accessibility Requirements: YES NO

2- Does this site offer handicapped access for the following: YES NO

Building: YES NO

Parking: YES NO

Restroom: YES NO

Other Handicapped Access: _____

3- Does this site offer other services for the disabled: YES NO

Text Telephone (TTY): YES NO

American Sign Language: YES NO

Mental/Physical Impairment Services: YES NO

Other Disability Services: _____

4- Accessible by Public Transportation: YES NO

Bus: YES NO

Subway: YES NO

Regional Train: YES NO

Other Transportation Access: _____

Doctor Signature: _____ Date: _____

Print Name: _____

CHILD CARE

ATTESTATION OF GOOD MORAL CHARACTER

By signing this form, I am swearing or affirming that I have not been found guilty or entered a plea of guilty or nolo contendere (no contest), regardless of the adjunction, to any of the following charges under the provisions of the Florida Statutes or under any similar statute of another jurisdiction. I also attest that I do not have a delinquency record that is similar to any of these offenses.

I understand I must acknowledge the existence of any criminal records relating to the following list regardless of whether or not these records have been sealed or expunged. I understand that I am also obligated to notify my employer of any possible disqualifying offenses that may occur while employed in a position subject to background screening under Chapter 435, Florida Statutes.

Relating to:

Sections: 393.135 relating to sexual misconduct with certain developmentally disabled clients

394.4593 relating to sexual misconduct with certain mental health patients

415.111 adult abuse, neglect, or exploitation of aged persons or disabled adults

741.30 domestic violence and injunction for protection (defined in 741.28) means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, ect. of a family or household member

782.04 murder

782.07 manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child

782.071 vehicular homicide

782.09 killing an unborn child by injury to the mother

784.011 assault, if the victim of offense was a minor

784.021 aggravated assault

784.03 battery, if the victim of offense was a minor

784.045 aggravated battery

784.075 battery on a detention or commitment facility staff

787.01 kidnapping

787.02 false imprisonment

787.04(2) taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings

787.04(3) carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person

790.115(1) exhibiting firearms or weapons within 1,000 feet of a school

790.115(2)(b) possessing an electric weapon or device, destructive device, or other weapon on school property

794.011 sexual battery

794.041 prohibited acts of persons in familial or custodial authority (former)

Chapter: 796 prostitution

Section: 798.02 lewd and lascivious behavior

Chapter 800 lewdness and indecent exposure

Section: 806.01 arson

Chapter: 812 felony theft and/or robbery and related crimes, if a felony

Sections: 817.563 fraudulent sale of controlled substances, if the offense was a felony

825.102 abuse, aggravated abuse, or neglect of disabled adults or elderly persons

825.1025 lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult

825.103 exploitation of disabled adults or elderly persons, if the offense was a felony

826.04 incest

827.03 child abuse, aggravated child abuse, or neglect of a child

827.04 contributing to the delinquency or dependency of a child

827.05 negligent treatment of children

827.071 sexual performance by a child

843.01 resisting arrest with violence
843.025 depriving an officer means of protection or communication
843.12 aiding in an escape
843.13 aiding in the escape of juvenile inmates in correctional institution
Chapter: 847 obscene literature
Section 847.05(1) encouraging or recruiting another to join a criminal gang
Chapter: 893 drug abuse prevention and control only if the offense was a felony or if any other person involved was a minor
Sections: 916.1075 relating to sexual misconduct with certain forensic clients
944.35(3) inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm
944.46 harboring, concealing, or aiding an escaped prisoner
944.47 introduction of contraband into a correctional facility
985.701 sexual misconduct in juvenile justice programs
985.711 contraband introduced into detention facilities

ONE OF THE FOLLOWING STATEMENTS MUST BE MADE:

Under the penalty of perjury, which is a first degree misdemeanor, punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding \$1,000 pursuant to ss.837.012, or 775.082, or 775.083, Florida Statutes, I attest that I have read the foregoing, and am eligible to meet the standards of good character for this caretaker position.

Signature of Affiant Date

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

Signature of Affiant Date

OR

**For Teachers and non-instructional personnel in lieu of fingerprint submission:
I swear or affirm that I have been fingerprinted under Chapter 1012, Florida Statutes, when employed as a teacher or non-instructional employee and have not been unemployed from the school board for more than 90 days. I swear the findings of that background check did not include any of the above offenses and that I meet the standards of good character for this caretaker position.**

Signature of Affiant Date

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

Signature of Affiant Date

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DOCTOR FAX COVER SHEET

Date: _____

Attn: Florida Heiken Children's Vision Program (State Wide Program)

Practice: _____ County: _____

Doctor: _____

Phone: _____ Fax: _____

Total Pages Including Cover Sheet: _____

Important Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message in error, please notify the sender immediately and destroy the related message.

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Optometrist Report

(PLEASE FAX REPORT TO # ABOVE)

School Name: _____ Exam Date _____

Student Name: File No: _____

Dear Parent/Guardian,

The following are your child's eye exam results. The examining physician's recommendations are below, as well as a copy of the glasses prescription. Please keep this for your records.

VISUAL ACUITY

Without glasses

Right Eye: 20 / _____

Left Eye: 20 / _____

With glasses

Right Eye: 20 / _____

Left Eye: 20 / _____

RESULTS (Please check one)

___ No further care or eyeglasses are indicated at this time. A yearly eye examination is recommended.

___ Prescription glasses would benefit your child. They will be delivered to the optometrist in approximately 3 weeks. A copy of the glasses prescription is written below.

___ Referral to other medical specialist is indicated for the following reason:
(This visit will not be covered by the Florida Heiken Program)

*Was a Dilated Eye Examination Performed as Required by the State of Florida **Circle: YES NO**
If NO Please Explain Reason: _____

GLASSES PRESCRIPTION

OD _____

OS _____

ADD _____ Use for _____

Doctor Signature _____ Lic # _____ Date _____

Doctor Name _____