APPLICATION TO THE HEALTH SERVICE EXECUTIVE

FOR THE PROVISION OF DENTAL PROSTHETIC TREATMENTS UNDER THE DENTAL TREATMENT SERVICES SCHEME

SECTION A:

APPLICANT BUSINESS DETAILS (BLOCK CAPITALS)

(1) FULL NAME _____

BUSINESS ADDRESS: _____

_____

BUSINESS TELEPHONE NUMBER(S): (353)

BUSINESS FAX NUMBER(S): (353)

MOBILE NUMBER (353)

BUSINESS E-MAIL ADDRESS (ES): _____

(2) An individual practising as a Clinical Dental Technician ☐

(3) Tax Clearance Certificate Number: _____
(Applicant must enclose a copy of their current, valid tax clearance certificate with this Application Form).

PPS Number: _____

(4) Does the Applicant or any Clinical Dental Technician employed by the Applicant hold a current agreement for the provision of Clinical Dental Technician services with the HSE?

(Tick as appropriate)

Yes: ☐ **No** ☐

If so, provide details: _____

_____DTSS Panel Number(s): _____

Has the Applicant or any Clinical Dental Technician employed by the Applicant held an agreement for the provision of Clinical Dental Technician services with the HSE in the past?

(Tick as appropriate)

Yes ☐ **No** ☐

If so, provide details: _____

_____ DTSS Panel Number(s): _____

(5) Has the Applicant or any Clinical Dental Technician employed by the Applicant ever been convicted of fraud or any other crime in any jurisdiction?

(Tick as appropriate)

Yes ☐ **No** ☐

If 'Yes', please provide the details including; name of individual, capacity, date of conviction and / or judgment, jurisdiction and nature of sanction:

_____

_____

_____

SECTION B: **(Please use BLOCK CAPITALS)**

DETAILS ARE REQUIRED FOR EACH PREMISES WHERE SERVICES ARE TO BE PROVIDED **(Please photocopy page and complete a sheet for each premises).**

(1) Practice Name: _____

(2) Practice Premises Address: _____

_____

(3) Number of Surgeries at this Practice Premises: ☐ **Are any Surgeries Wheelchair Accessible? Y/N** ☐

(4) Telephone Number: (353) **(5) Fax No:** (353)

(5) Mobile Number: (353)

(6) E-Mail Address: _____

(7) Practice Hours:

Monday:	**From: _____To: _____**	**From: _____ To: _____**
Tuesday:	**From: _____To: _____**	**From: _____ To: _____**
Wednesday:	**From: _____To: _____**	**From: _____ To: _____**
Thursday:	**From: _____To: _____**	**From: _____ To: _____**
Friday:	**From: _____To: _____**	**From: _____ To: _____**
Saturday:	**From: _____To: _____**	**From: _____ To: _____**
Sunday:	**From: _____ To: _____**	**From: _____ To: _____**

(8) Provide details of any ICT System (clinical and/or administrative) that will be operated for the Agreement:

_____

_____

To facilitate on-line claiming for Fees and agreement management, the Applicant may be required to ensure that their ICT systems are compatible with the HSE's ICT systems and meet the approval of the HSE.

(9) Provide Details of Public Liability Insurance - Please Attach Copy of Policy Schedule (Refer to 2.1.7):

Details and Level of Cover: _____

Policy Provider and Number: _____

Expiry Date: D D M M Y Y Y Y **Copy of Policy Schedule attached – 'tick'** ☐

(10) Provide Details of Employer's Liability Insurance - Please Attach Copy of Policy Schedule (Refer to 2.1.7):

Details and Level of Cover: _____

Policy Provider and Number: _____

Expiry Date:

D	D	M	M	Y	Y	Y	Y

Copy of Policy Schedule attached – 'tick' ☐

SECTION C: **(Please use BLOCK CAPITALS)**

DETAILS OF EACH CLINICAL DENTAL TECHNICIAN ("CDT") IT IS PROPOSED WILL CARRY OUT THE SERVICES UNDER THE AGREEMENT

(Please photocopy page and complete a sheet for each CDT).

(1) Full Name: _____ **(2) Date of Birth:** | D | D | M | M | Y | Y | Y | Y |

(3) Address:
(for correspondence) _____

_____

_____

(4) Irish Dental Council Registration Number: _____

Copy of Policy Schedule attached – 'tick' ☐

(5) Previous holder of a DTSS Agreement(s)? Yes ☐ **No** ☐

If yes, DTSS Panel Number(s): _____

(6) Did CDT previously participate in any publicly funded dental services scheme(s) in any jurisdiction (other than the DTSS)?

Yes ☐ **No** ☐

If 'Yes', provide details and attach references from the competent authority in that jurisdiction:

_____

_____

(7) Details of current Professional Indemnity Insurance Policy – Please attach a copy of policy Schedule (Refer to 2.7.1)

Details of Cover: _____

Policy Provider and Number: _____

Expiry Date: | D | D | M | M | Y | Y | Y | Y | **Copy of Policy attached – 'tick'** ☐

(8) Are you or have you ever been the subject to an investigation by a Dental Competent Authority, or the Gardaí/Police in this or any other jurisdiction?

Yes ☐ **No** ☐

If yes, please give full details:

_____

_____

_____

_____

(9) DECLARATION:

I, _____, the CDT, confirm that:

The above information is current, accurate and complete.

Signed: _____ Date: _____

Print Name:_____

To be completed only in respect of the Applicant

Health Service Executive
Primary Care Reimbursement Service
Units 1-5 Ground Floor
J5 North Park Offices
North Park Business Park
Exit 5, M50
North Road
Finglas
Dublin 11

Tel: (01) 864 7100
Fax: (01) 834 3589

PAY MANDATE FORM – Dental

- This form is to be used to supply or change bank account details for your contract
- Please use black pen and use block capitals except where signature is required
- Any corrections must be initialled
- Only signatory on contract should sign this form
- All fields must be completed*
  **Contractors yet to be allocated a contract number should leave the contract number field blank*

HSE Contract Number: | | | | | |

Contractor Name: _____

Business Address Line 1: _____

Business Address Line 2: _____

Business Address Line 3: _____

Business Address Line 4: _____

Business Telephone No: _____ Fax No: _____
(Please include pre-fix)

PPS Number:									

Signature of Contractor _____

Name (Block Capitals) _____

Date: | D | D | M | M | Y | Y | Y | Y |

Name and Address of Bank:
_____

Full Name in which account is held: _____

IBAN																										
BIC										X	X	X	X													

New Contractors: Please return completed form and relevant attachments to your relevant local office.

Note: Applicant must notify HSE of any changes in writing on business headed paper and include DTSS panel number and official stamp.

SECTION E:

GENERAL TERMS AND CONDITIONS

1. Who can hold an Agreement for the provision of Clinical Dental Technician services?

1.1. An agreement for the provision of dental prosthetic treatments may, subject to the HSE's discretion, be held by an individual practicing as a CDT;

1.2. The Applicant must be able to provide the full range of services set out in the draft agreement documentation provided with this Application at the Premises listed in Section B.

2. Criteria for the Award of an Agreement

2.1. In coming to a decision on whether or not to award an agreement to an Applicant, the HSE shall have regard to its statutory functions, duties and objectives, including the requirement for it to manage its resources effectively. It shall also consider whether or not the Applicant meets the following criteria:

2.1.1. Each Clinical Dental Technician who is to provide the dental prosthetic treatments under the Agreement must be registered on the register of Clinical Dental Technicians maintained by Irish Dental Council and shall provide on an annual basis confirmation of their current registration with the Dental council.;

2.1.2. Each premises listed in Section B must be approved by the HSE;

2.1.3. The Applicant must furnish annually an up-to-date tax clearance certificate to the HSE;

2.1.4. The HSE is provided with full information in relation to, and is satisfied with, the professional record of the Applicant and any CDTs proposed to provide Services under the Agreement.

2.1.5. Where the Applicant or any Clinical Dental Technician employed by the Applicant held an agreement for the provision of Clinical Dental Technician services with the HSE previously, the HSE was satisfied with the standard of performance under that agreement.

2.1.6. The HSE is provided with full information in relation to, and is satisfied with, the criminal record of the Applicant and any CDTs proposed to provide Services under the Agreement.

2.1.7. The Applicant can demonstrate that it meets the following minimum insurance requirements:

2.1.7.1. Public Liability with a limit of indemnity of €6,500,000;
2.1.7.2. Employers Liability with a limit of indemnity of €13,000,000; and
2.1.7.3. Professional Indemnity with a limit of indemnity of €6,500,000.

2.1.8. The Applicant must provide evidence to the HSE that all appropriate pre-employment checks, including Garda/Police vetting checks, have been carried out on all of its employees and on any CDT providing the dental prosthetic treatments under the Agreement.

3. Rejection of Application and Appeal

3.1. Where an Application is rejected, the HSE shall inform the Applicant in writing of its decision and the reasons therefore.

3.2. The Applicant may, within 15 days of being informed of the rejection of its Application, request in writing that an internal review of the decision is carried out by the HSE.

4. Successful Applicants

4.1. A successful Applicant shall be added to the HSE's Panel of individuals who are engaged in the provision of dental prosthetic treatments pursuant to an agreement with the HSE for a defined period of five (5) years, in accordance with the terms and conditions of the Agreement.

SECTION E:

DECLARATION*

I, _____, being the Applicant for an agreement for the provision of Clinical Dental Technician services, confirm that I wish to provide the services in accordance with the draft agreement documentation provided with this Application. I hereby declare that all of the details provided in this Application (Sections A through E) are accurate and current and that no information requested has been withheld.

I acknowledge that the HSE may terminate the Agreement if it is revealed that any of the details provided herein in this Application are inaccurate or incorrect.

I further acknowledge that it is open to the HSE to take any necessary steps to validate the details provided in this Application and that, inter alia, it may be necessary for the HSE to inspect the Premises identified in Section B of this Application.

*Failure to sign this declaration will render the application invalid.

Signed: _____
Clinical Dental Technician

Print Name in BLOCK CAPITALS: _____

In the presence of:_____

Print Name in BLOCK CAPITALS: _____

Date:

D	D	M	M	Y	Y	Y	Y