# Alaska's SHARP Program

*Recruitment & Retention Services for Alaska's Healthcare Workforce*

Amendment to SHARP Memorandum of Agreement of (_date_)
Between the following Parties:

Practitioner: [____], Dentist, and
Site: [_____], and
State of Alaska, Department of Health and Social Services

## I. PURPOSE AND SCOPE

This Amendment revises the Memorandum of Agreement (MOA) that exists between the State of Alaska, Department of Health and Social Services (Alaska DHSS), SHARP Program (SHARP), the above-named licensed and otherwise program-eligible health care practitioner (Practitioner or Clinician) who participates in the SHARP Program, and the above-named eligible health care delivery entity, [_____] (Site or Employer). This Amendment changes only those term(s) of the Practitioner's original MOA that are itemized below. All other terms of original MOA remain in effect.

This Amendment modifies the definition of Direct Patient Care as related to dentists who work at a program employing Dental Health Aide Therapists.

## II. AMENDMENT TO MOA AND RATIONALE

"Direct Patient Care: The direct delivery of healthcare services to a patient (aka direct care), the occurrence of which is not mediated by others, including clinical supervisees.

> For Dentists: Direct care also includes DIRECT supervision of Dental Health Aide Therapists (DHATs) as defined by the Community Health Aide Program Certification Board Standards and Procedures."

Regarding SHARP Quarterly Work Reports, the Dentist will submit regular counts of patients who have received direct patient care (DPC), and the number of DPC visits. For Dentists, the QWR enumeration will also include all patients who are jointly served by the presiding dentist and each DHAT who is receiving that Dentist's direct supervision.

## III. REVISED PERIOD OF AGREEMENT

A. Date of original MOA: [_____]
B. Date of amended definition: [_____]
C. Scheduled MOA End Date: [_____]

I hereby agree to all terms of the preceding MOA as well as the foregoing Amendment, and certify that any and all information I have provided therein is accurate to the best of my knowledge.

For: **HEALTH CARE PRACTITIONER** (aka Clinician)

By: _____ _____
(Signature of Practitioner) Date

Practitioner's Name - print: [_____]

Social Security Number: _____

Notary Public: _____ _____
(Notary re: Practitioner's Signature) Date

For: **HEALTH CARE DELIVERY SITE** (aka Agency)

By: _____ _____
(Authorized Representative for Site) Date

Representative's Name - print: [_____]

Name of Service Site: [_____]

Location of Eligible Service Site (including 9-digit zip code):

_____

For: **ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES**

By: _____ _____
Jill Lewis, Deputy Director Date
Division of Public Health,
Alaska Department of Health & Social Services

By: _____ _____
Robert Sewell, Ph.D., Program Manager Date
Alaska's SHARP Program
Section of HPSD, Division of Public Health
Alaska Department of Health & Social Services