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Enclosed you will find the client enrollment forms for the Ryan White Dental Program (RWDP). Please complete all information to the best of your ability. **PLEASE NOTE THE REQUIRED VERIFICATIONS AND FORMS HAVE CHANGED. ALSO NOTE THAT WE ARE NOW REQUIRED TO COLLECT FINANCIAL, MEDICAL INSURANCE AND RESIDENCY VERIFICATIONS EVERY SIX MONTHS FOR ACTIVE CLIENTS.**

In order to receive services from the RWDP, clients must be diagnosed with HIV/AIDS and reside in Massachusetts or the three southeastern counties of New Hampshire. Anyone regardless of income can be advised and referred to a dentist. If the client needs financial assistance their gross annual income must not exceed 500% of the federal poverty level (2018: $60,700; add $4,320 per dependent.)

If a client has MassHealth, they are required to see a dentist who accepts MassHealth. If a client has private dental insurance, the RWDP cannot pay for any co-payments and remaining balances. These are the guidelines outlined in our grant, and they are strictly enforced.

Please do not make a dental appointment without confirming it with us. The program has special arrangements with many of the dentists, and referrals should come directly from our staff.

Once an application is approved a letter will be sent explaining the dates of coverage. If client would like mail sent to case manager, please provide the case manger's address in the "Mailing Address" line.

Applications may be submitted to us via fax or mail. Please feel free to contact us if you have any questions.

Ryan White Dental Program

1010 Massachusetts Avenue 2nd Floor • Boston, Massachusetts 02118
TEL 617/534-2344 • FAX 617/534-2819

Ryan White Dental Program Enrollment Checklist

- ❑ **<u>Complete Enrollment Form</u>**

- ❑ **<u>Consent for Release of Information</u>** -Please read carefully, complete, sign and date it. If we have not set up a dental referral, please leave the dentist fields blank.

- ❑ **<u>Ryan White Dental Program Grievance Procedure</u>** -Please read carefully, sign and date it.

- ❑ **<u>Client Income Summary Form</u>** -Please sign the form and date it.

- ❑ **<u>Proof of HIV Status</u>**- Letter signed by Physician or Nurse Practitioner stating HIV status. Lab results are also acceptable. (If this is an update, verification on file may be used.)

- ❑ **<u>Proof of Income</u>**- (maximum annual income to receive financial assistance is $60,700 per family of one) --**only submit one**:
  - 2 pay stubs
  - copy of most recent tax form
  - copy of SSI/SSDI statement
  - Letter from case manager attesting to your income.

- ❑ **<u>Proof of Residency</u>** – (program requires primary residence in Massachusetts or these New Hampshire counties: Hillsborough, Rockingham, and Strafford. This must match the address on Client Enrollment Form) --**only submit one**:
  - 2 pay stubs showing your address
  - copy of most recent tax form showing your address
  - copy of SSI/SSDI statement showing your address
  - copy of utility bills
  - copy of active driver's license or state identification card
  - copy of Health Insurance Premium statement showing your address
  - Letter from case manager attesting to your residency.

- ❑ **<u>Proof of Medical Insurance</u>** -- **only submit one**:
  - HDAP approval letter
  - Letter from insurer
  - Health Insurance Premium statement
  - MassHealth Approval Letter
  - copy of Medicare card -**NO OTHER CARD IS ACCEPTABLE**
  - Letter from case manager attesting to your medical insurance.

As a reminder, the RWDP does not cover co-pays or remaining balances from any other dental insurance. RWDP can only pay if all other insurers have declined to pay and it is within the RWDP scope of service. Please note once an individual is enrolled, they must update their files every six months to remain active. RWDP can only pay for services while coverage is active. Please submit forms and verifications via mail or fax.

05/30/18

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Ryan White Dental Program
Client Enrollment Form

For office use only: ☐ New client ☐ Updated client

Date: ___/___/___

SECTION 1 – PATIENT IDENTIFICATION

First Name: ____ MI: ____ Last Name: ____

Date of Birth: ___/___/___ Last 4 digits of SSN: ____ Mother's First Name: ____

Sex at birth: *Please select one* ☐ Male ☐ Female

Current Gender: *Please select one* ☐ Male ☐ Transgender ☐ Female ☐ Unknown

If transgender: ☐ Male to Female ☐ Unspecified ☐ Female to Male

SECTION 2 – CONTACT INFORMATION AND DEMOGRAPHICS

Street Address: ____

City: ____ State: ____ Zip: ____ ☐ Check if Same as Mailing Address

Mailing Address: ____

City: ____ State: ____ Zip: ____

Phone: ( ) ____ Email: ____

Can we call you? ☐ Y ☐ N Can we leave messages? ☐ Y ☐ N I would like all my RWDP mail sent to my case manager

Case Manager: ____ Phone: ( ) ____

Agency: ____ Email: ____

Race: *Please select all that apply*

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown/Do Not Identify

Ethnicity: *Please select one*

☐ Hispanic/Latino(a)

☐ Non-Hispanic/Latino(a)

☐ Unknown

Additional Racial/Ethnic Groups: *Please select all that apply*

☐ Brazilian ☐ Cape Verdean ☐ Eastern European ☐ Haitian ☐ Portuguese

☐ Southeast Asian ☐ Sub-Saharan African ☐ Other, please specify: ____

Country of Birth: ____ Primary Language: ____

- If non-U.S. born, year arrived: ____

SECTION 3 – HIV STATUS AND DIAGNOSIS

Year of HIV Diagnosis: ____ Recent CD-4 Count: ____ Date: ___/___/___

Year of AIDS Diagnosis (if applicable): ____ Recent Viral Load: ____ Date: ___/___/___

HIV Exposure Category: *Please select all that apply*

☐ Men who have sex with men (MSM) ☐ Injection drug users (IDU)

☐ Heterosexual contact ☐ Perinatal transmission

☐ Hemophilia/Coagulation disorder ☐ Through blood, blood products, tissue

☐ Other risk ☐ Unknown

HIV Medication Side Effects: ☐ None ☐ Mild ☐ Moderate ☐ Intolerable

Do you take your HIV Medications?

☐ Not on medications

☐ Always take medications

☐ If you missed doses how many this week? __________

Primary Care Doctor: [ ] **Date of last visit:** [ ]/[ ]/[ ]

Phone: ( ) [ ]

Diagnosed with Hepatitis C (HCV)? ☐ Y ☐ N

Medical/Dental Appointments: ☐ Missed all ☐ Kept some ☐ Kept most ☐ Kept all

Mental Health Status: ☐ In crisis ☐ Poor ☐ Fair/good ☐ Excellent

SECTION 4 – INCOME, INSURANCE AND HOUSING

Employment Status: ☐ Y ☐ N **Annual Income:** [ ] **Family Size:** [ ]

Health Insurance:

☐ None

☐ Medicare

☐ Private ☐ Other [ ]

MassHealth: ☐ Standard ☐ Limited

Dental Insurance:

☐ None

☐ Medicare

☐ Private ☐ Other [ ]

MassHealth: ☐ Standard ☐ Limited

Housing Status: *Please select one*

☐ Permanent housing ☐ Transitional housing ☐ Emergency shelter

☐ Psychiatric facility ☐ Substance abuse treatment facility ☐ Incarcerated

☐ Temporarily staying in family's/friend's home

If permanent housing:

☐ Owned ☐ Rental

Is rental subsidized? ☐ Y ☐ N

SECTION 5 – DENTAL SERVICES

Dental Problem: [ ]

Note if patient has any of the following: ☐ Pain ☐ Bleeding ☐ Swelling ☐ Oral Lesions ☐ Missing Teeth

Location of last dental visit: [ ] **Phone:** ( ) [ ]

Was the dental office aware of HIV status? ☐ Y ☐ N ☐ N/A

Were you satisfied with care? ☐ Y ☐ N

Date of appt.: [ ]/[ ]/[ ]

Reason for visit: ☐ Routine ☐ Emergency ☐ Surgery ☐ Endo ☐ Prosth ☐ Perio ☐ Other

If patient has not seen dentist in past twelve months, please indicate reason(s):

☐ Financial ☐ Disclosure/Confidentiality ☐ Discrimination ☐ Not Convenient ☐ Moved/Distance ☐ Fear

☐ Missing/Unknown ☐ Other

CONSENT FOR RELEASE OF INFORMATION

I, ______________________________:

- Authorize the Ryan White Dental Program (RWDP) at the Boston Public Health Commission to disclose to dental provider: ______________________________ my name and eligibility in the RWDP, which includes my HIV status.

- Authorize the release of my dental treatment plan(s) and other confidential health information from: ____to RWDP for the purpose of determining my eligibility into RWDP. This may include, but not be limited to, information such as my name, diagnoses related to HIV status, substance abuse treatment information, financial circumstances, and living arrangements. I understand that review of my file by RWDP staff will only be used to determine my eligibility in the RWDP and that the information will never be copied or shared outside of RWDP unless expressly authorized by myself.

- Authorize the release of my dental treatment plan(s) and confidential information to discuss with my case manager: ________________________________.

- Authorize RWDP to discuss confidential information with my primary care physician, Dr.____.

- Authorize RWDP to discuss my dental information, which may include disclosure of my HIV status, with my significant other, sibling, parent, guardian ad litem, peer advocate, or other: ____.

This consent is subject to revocation at any time except to the extent that the program/provider which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one (1) year after it is signed.

Signature of patient: ______________________________ Date:__________________

Signature of parent/ : _____________________________Date:__________________
guardian (where required)

05/30/2018

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Ryan White Dental Program (RWDP) Grievance Procedure

Client complaints are given serious consideration. They are managed depending on the target and nature of the complaint.

During the RWDP intake process, the client should be made aware of grievance procedures against either a RWDP-associated dental provider or the RWDP itself.

1) If a client has a concern about a dental provider to whom s/he was referred by the RWDP, the client should be advised to call the RWDP at 617-534-2344 for resolution and/or a new referral.

2) Clients should be told that complaints against the RWDP or its staff may be directed to the RWDP Director. If this is not satisfactory to the client or his/her agent, the complaint may be brought to the Director of the Boston Public Health Commission's Infectious Disease Bureau at (617) 534-5611.

If someone calls the RWDP regarding a complaint about against a non-RWDP dental provider, the person should be advised of the following options:

a) Contact the Board of Registration in Dentistry
b) Contact a lawyer

Client Signature: ___________________________________

Print Name: ____

Date: _____/______/___________

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Client Income Summary

The purpose of this form is to document financial eligibility for Ryan White HIV/AIDS Program services. The form can be shared among service providers to verify income screening if the client has signed and dated a release of information document. *This form is valid for six months after the screening date.*

Agency name:	
Agency address:	
Agency phone number:	
Client name:	**Client Code:**
Screening date:	**Expiration date (six months after screening):**

Annual income:
To determine if the client's gross annual income is less than 500% of the FPL, if the client provides a pay stub, the gross year-to-date ("YTD") is used to calculate gross annual income. If the pay stub does not show gross YTD, the client must provide two pay stubs, so that yearly gross earnings can be calculated using the client's average earnings for the designated pay period. If the client is not working, but receives SSI, SSDI, or any other type of monetary benefit, proof of this must also be shown. If the client is not working and has no income, or if he/she is working but cannot provide proof of this, a letter from the client's medical case manager is required. If the client does not have a medical case manager, then a letter from his/her clinician is required. If a client is over-income, check to see if the client has dependents. If so, documentation must be provided (usually a copy of page one from the most recent U.S. 1040 tax return, if available), and an additional $4,320 (as of 2018) is then allowed for each dependent.

CLIENT ANNUAL INCOME: $

Documentation provided for client record (check all that apply):
Pay stub(s) Social Security Administration (SSDI/SSI) letter Private disability statement
Department of Transitional Assistance (TANF/EAEDC) letter Veterans' Benefits
Other: ________________________

Federal Poverty Level:
Consult the U.S. Department of Health and Human Services poverty guidelines for the current calendar year at http://aspe.hhs.gov/poverty. Based on the client's gross annual income, what is the applicable Federal Poverty Level (FPL) range? **FPL: %**

Signatures:
Client: ____ Date: _________________
Agency staff (person completing the form): ________________________________ Date: _________________
Title: ____