



HIV Dental Program Enrollment Checklist

All new clients require:

- Consent Form/Appendix D
- Intake Form
- Joint Client Information Form (**Leave “Contract Information” and “Medical Information” Blank**)
- Proof of HIV Status
A letter signed by Physician or NP, proving client is HIV positive on office letterhead.
- Proof of Income
This can be any of the following: a copy of two most recent pay stubs, copy of most recent tax form, copy of SSI/SSDI statement, copy of MassHealth card, or letter from licensed social worker stating income status.

Please fax or mail these forms and verifications to the HIV Dental Program. Please mark the information “CONFIDENTIAL” on the fax cover sheet or outside envelope.

Fax: (617) 534-2819

Mail: BPHC / HIV Dental Program
774 Albany St, 2nd floor
Boston, MA 02118



APPENDIX D

CONSENT FOR REIMBURSEMENT AND RELEASE OF INFORMATION

I _____ (Patient Name), authorize the:

HIV Dental Ombudsperson Program and the referring or assigned dental provider,

Dr. _____

- To release information pertaining to my HIV status and dental treatment claim forms solely for reimbursement for dental services by the Dental Treatment Fund, HIV Dental Ombudsperson Program, Boston Public Health Commission. Reimbursement is provided under a grant from the Ryan White Part A. I give my permission for client data to be reviewed by the Ryan White Part A staff. This data may include items regarding diagnoses related to HIV status, name, substance abuse treatment, financial circumstances, living arrangements, and other client information, as requested. I understand that review of client files will be visual only, no records will be copied, and no information identifying me will be recorded.
- To discuss confidential information with my case manager (if applicable) _____ (Name) and my primary care physician Dr. _____ (Name) in order to keep my records current so my dental care can continue.

This authorization is granted on the condition that due care must be exercised with respect to my rights to privacy and confidentiality. My consent is valid so long as I am an active client of the HIV DOP. I understand that I may revoke this authorization in writing at any time.

I understand my rights are protected under the Health Information Portability and Accountability Act.

Date: _____

Signature: _____

Witnessed: _____

HIV Dental Program · Boston Public Health Commission · Intake Form

SECTION 1

Referred by: _____ Date: ___/___/___

First Name: _____ Last Name: _____

CLIENT CODE: First 3 Letters of Mother's First Name: ___ ___ ___

Date of Birth: ___/___/___

Last 4 Digits of Social Security Number: ___ ___ ___ ___

Phone: (____) _____ Contact Person: _____

Can we call you at this number? Y N Relationship: _____

Can we leave messages? Y N Phone: (____) _____

Street Address: _____ City: _____ St: ___ Zip: _____

Can you receive mail at this address? Y N

Mailing Address: _____ City: _____ St: ___ Zip: _____

Housing Status: Homeless Non-Permanently Housed Permanently Housed

Marital Status: Married Single Divorced Other

Employment Status: Y N Annual Income: _____ Dependants: ___ ___

Health Insurance: None MassHealth Medicare Private FreeCare Other

Dental Insurance: None MassHealth Private Other

Transportation: Private Vehicle Public Transportation

Year of HIV Diagnosis: _____ Year of AIDS Diagnosis (if applicable): _____

Recent CD-4 Count: _____ Recent Viral Load: _____

Medical/Dental Appointments: Missed All Kept Some Kept Most Kept All

Adherence to HIV Medications: N/A(not on ART) None Sometime Frequently Always

Primary Care Doctor: _____ (____) _____

SECTION 2

Chief Dental Problem: _____

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

Date of last dental visit: ___/___/___ Reason for visit: Routine Emergency Surgery

Endo. Prosth. Perio Other

If patient has not seen dentist in past twelve months, indicate reason or reasons:

Financial Disclosure/Confidentiality Discrimination Not Convenient

Moved/Distance Fear Missing/Unknown Other

Name/Location of last dental visit: _____ Phone: (____) _____

Satisfied with the care? Y [] N [] Dental office aware of HIV status? Y [] N [] N/A []

SECTION 3

Dental Office Referred to: _____

Grievance Policy Discussed [] Consent Form Singed [] HIV Verification [] Financial Verification []

Joint HIV/AIDS Client Information Form
Boston Public Health Commission / AIDS Program
Massachusetts DPH HIV / AIDS Bureau

Date Completed

 month / day / year

New Client
 Update

Completed By

Client Code

First 3 letters of client's Mother's first name (XXX if unknown) – 6 digit DOB – Last 4 digits SS# (9999 if unknown)

General Information

Birth Date

 month / day / year

Gender (Choose one)
 01 = Male
 02 = Female
 03 = Transgender
 99 = Unknown / Unreported

Age

City

State **Zip**

Contract Information

Vendor

Intake Date
 month / day / year

Activity Status (Circle One)
 01 = Active
 02 = Deceased
 03 = Other inactive status
 04 = Moved
 05 = Lost to follow-up
 06 = Changed Provider
 07 = Discharged

DPH	BPHC – Part A
Client Services <input type="checkbox"/>	Part A <input type="checkbox"/>
Home Health <input type="checkbox"/>	
Medical Mgt <input type="checkbox"/>	
Housing <input type="checkbox"/>	
Corrections <input type="checkbox"/>	

Case Manager (Optional)

Ethnicity / Race

Hispanic or Latino/a	Federal Race Categories	Other Racial or Ethnic Groups
You MUST circle one.	Choose as many as applicable but you MUST circle at least one.	In ADDITION to the categories on the left, you may choose one or more from the following. Write in any other groups below.
01 = Hispanic or Latino/a 02 = Not Hispanic or Latino/a 99 = Unknown / Unreported Country of Birth (select one) 01 = United States 02 = United States Dependencies (including Puerto Rico) 03 = Other	01 = White 02 = Black or African American 03 = Asian 04 = Native Hawaiian / Pacific Islander 05 = American Indian / Alaskan Native 99 = Unknown / Unreported (“99” Includes Latinos who do not identify with any of the 5 Federal race categories.)	<input type="checkbox"/> African <input type="checkbox"/> Cape Verdean <input type="checkbox"/> Haitian <input type="checkbox"/> Brazilian <input type="checkbox"/> Portuguese
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Language
Choose One

01 = English
 02 = Spanish
 03 = Haitian Creole
 04 = French
 05 = Portuguese
 06 = Crioulo (Cape Verdean)
 07 = S.E. Asian Language
 08 = American Sign Language
 98 = Other (specify below)

Exposure Category
Choose as many as applicable

01 = Men who have sex with men (MSM)
 02 = Women who have sex with women (WSW)
 03 = Injection drug users (IDU)
 04 = Heterosexual contact
 05 = Perinatal transmission
 06 = Hemophilia / Coagulation disorder
 07 = Through blood, blood products, tissue
 98 = Other risk
 99 = Undetermined / Unknown

Diagnostic Information
Choose one

* 01 = HIV+, not AIDS
 * 02 = HIV+, AIDS status unknown
 * 03 = AIDS, CDC defined
 04 = HIV negative (affected clients)
 05 = HIV indeterminate (under age 2 only)
 99 = Unknown / Unreported
 * **HIV verification is required**

Referral Source **Choose one**

01 = Self	06 = Detoxification Program	10 = Health Center
02 = Case Management	07 = Homeless Service	11 = STD Clinic
03 = Substance Abuse Trtmnt Prog.	08 = Counseling/Testing Site	12 = Emergency Room
04 = Adult/Juvenile Detention Facility	09 = Mental Health Program	98 = Other
05 = Prevention/Education Program		

