



HIV Dental Program Enrollment Checklist

All new clients require:

- **Intake Form-** “Section 1” must be complete.
- **Joint Client Information Form** -Leave “Contract Information” and “Medical Information” Blank.
- **Signed Consent Form/Appendix D**
- **Signed Grievance Policy**
- **Proof of HIV Status** - Letter signed by Physician or NP, proving client is HIV positive on office letterhead.
- **Proof of Income** - Pay stub, copy of most recent tax form, copy of SSI/SSDI statement, copy of MassHealth card, or letter from licensed social worker.

Please submit enrollment forms and verifications via mail:

HIV Dental Program/ BPHC

1010 Massachusetts Avenue

Boston, MA 02118

or fax:

(617) 534-2819

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.



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, and 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

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: (_____) _____ Case/Medical Manager: _____

Can we call you at this number? Y N

Phone: (_____) _____

Can we leave messages? Y N

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

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

Current 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

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



HIV Dental Ombudsperson Program Grievance Procedure

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

During intake process the client should be made aware of grievance procedures against either a dental provider or the HIV DOP.

- 1) If a client has issue with the provider they are referred to by the HIV DOP, they should be instructed to call HIV DOP for a resolution and/or new referral. The phone number is (617) 534-2344.
- 2) If they are referred to HIV DOP as a result of a grievance against a provider outside of the program, then the guidelines for discrimination calls should be followed and an intake completed or updated depending on the client's enrollment status. They should be informed of the series of options available wherein the grievance may be resolved:
 - a) Director contacts the dental provider
 - b) Complaint filed with Board Of Registry In Dentistry
 - c) Referral to legal action
- 3) Clients should be aware that complaints against the HIV DOP or its staff may be directed to the program. 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 AIDS Program at (617) 534-4559.

Client Signature: _____

Date: ____/____/____

