03/19/2025

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. **WE ARE NOW REQUIRED TO COLLECT FINANCIAL, MEDICAL INSURANCE, AND RESIDENCY VERIFICATIONS EVERY TWELVE MONTHS FOR ACTIVE CLIENTS.**

Re-certification applications sent earlier than 30 days before the previous expiration date will not be processed, you will be notified, and the application will be destroyed.

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 (2025: $78,250; add $27,500 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.

Before making a dental appointment, YOU MUST CONFIRM your eligibility and the participation status of the dental office. The program has special arrangements with contracted dentists, and referrals should come directly from our staff. Dental offices may have policies against no-shows, late fees, and other penalties for no-show, no-call appointments. RWDP cannot reimburse you for these costs. It is highly advised to be in communication with your dental office about scheduling issues.

Once an application is approved a letter will be sent explaining the dates of coverage. If a client would like mail sent to the case manager, please provide the case manager'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. Program information and forms can also be found at **boston.gov/bphc-rwdp**.

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

- ❑ **Complete Enrollment Form**

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

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

- ❑ **Proof of HIV Status**- 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.)

- ❑ **Proof of Income**- (maximum annual income to receive financial assistance is $78,250.00 per family of one) --**only submit one**:

  - copy of most recent tax form
  - copy of SSI/SSDI statement
  - 2 most recent pay stubs
  - Letter from case manager attesting to your income.

- ❑ **Proof of Residency** – (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.

- ❑ **Proof of Medical Insurance** -- **only submit one**:
  - HDAP approval letter
  - Letter from insurer
  - Health Insurance Premium statement
  - MassHealth Approval Letter
  - copy of Insurance card
  - 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 twelve months to remain active. RWDP can only pay for services while coverage is active. Please submit forms and verifications via mail or fax.

03/19/2025

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CONSENT FOR RELEASE OF INFORMATION

I, _____:

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.

II. 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.

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

IV. Authorize RWDP to discuss confidential information with my primary care physician: _____.

V. 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: _____.

* _____ (Initial) I consent to the use of phone and email communication between myself and RWDP.
* _____ (Initial) I consent to the use of phone and email communication between RWDP and my case manager to confirm my name and eligibility, treatment plans, and other confidential information as necessary for my compliance in RWDP.
* _____(Initial) I consent to the use of phone and email communication between RWDP and my dental provider to confirm my name and eligibility, treatment plans, and other confidential information as necessary for my compliance in RWDP.

I accept the risks to the forms of release outlined above, despite the precautions undertaken by RWDP for confidentiality. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. 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/guardian:_____ Date: _____
(where required)

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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: *Check one* ☐ Male ☐ Female

Current Gender: *Check one* ☐ Male ☐ Transgender ☐ Female ☐ Unknown

If transgender *check one:* ☐ Male to Female ☐ Female to Male ☐ Unspecified

SECTION 2 – CONTACT INFORMATION AND DEMOGRAPHICS

Street Address: **City:**

State: **Zip Code:**

☐ *Check if same as Mailing Address* ☐ *Check if client is currently unhoused*

Mailing Address: **City:**

State: **Zip Code:**

Phone: **Email:**

*Check Yes **or** No in the box below:*

a) Can we call you? ☐ Yes ☐ No

b) Can we leave voicemail messages? ☐ Yes ☐ No

c) Can we email you? ☐ Yes ☐ No

d) I would like all mail sent **only** to my case manager ☐ Yes ☐ No

Case Manager: **Agency:**

Phone: **Email:**

Mailing Address: **City:**

State: **Zip Code:**

Race. *Check all that apply:*

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

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

Ethnicity. *Check one box:*

☐ Hispanic/Latino(a) ☐ Non-Hispanic/Latino(a) ☐ Unknown

Additional Racial/Ethnic Groups. *Check all that apply:*

☐ Brazilian ☐ Cape Verdean ☐ Eastern European

☐ Haitian ☐ Portuguese ☐ Southeast Asian

☐ Sub-Saharan African ☐ Other (please specify):

Primary Language:

Country of birth:

Year of US Entry (if non-US born):

SECTION 3 – HIV STATUS AND DIAGNOSIS

Date of HIV Diagnosis: (*MM/DD/YY*)

Date of AIDS Diagnosis (*if applicable*): (*MM/DD/YY*)

Recent CD4 Count:

Date: (*MM/DD/YY*)

Recent Viral Load:

Date: (*MM/DD/YY*)

HIV Exposure Category: *Check all that apply*

☐ Men who have sex with men (MSM) ☐ Injection drug users (IDU) ☐ Heterosexual Contact ☐ Hemophilia/ Coagulation Disorder

☐ Through blood, blood products, tissue ☐ Other ☐ Unknown

Primary Care Doctor:

Date of last visit: (*MM/DD/YY*)

Phone:

Have you been diagnosed with Hepatitis C (HCV)? ☐ Yes ☐ No

SECTION 4 – INCOME, INSURANCE, AND HOUSING

Employed? ☐ Yes ☐ No

Annual Income:

Family Size:

Health Insurance: *Check all that apply*

☐ None
☐ Medicare
☐ Private
MassHealth: ☐ Standard ☐ Limited
☐ Other:

Dental Insurance: *Check all that apply*

☐ None
☐ Medicare
☐ Private
MassHealth: ☐ Standard ☐ Limited
☐ Other:

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: *Check all that apply*

☐ Pain ☐ Bleeding ☐ Swelling ☐ Oral Lesions ☐ Gum Disease ☐ Tooth Decay ☐ Broken/Chipped Tooth
☐ Missing Teeth ☐ Needs Dentures

Location of last dental visit:

Phone:

Date of last appointment: (*MM/DD/YY*)

Reason for visit: ☐ Routine ☐ Emergency ☐ Surgery
☐ Endodontic ☐ Prosthetic ☐ Periodontic ☐ Other

Was the dental office aware of HIV status? ☐ Yes ☐ No **Were you satisfied with care?** ☐ Yes ☐ No

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

☐ Financial ☐ Disclosure/Confidentiality ☐ Discrimination ☐ Not Convenient
☐ Fear ☐ Move/Distance ☐ Missing/Unknown ☐ Other

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.

I. 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.

II. 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 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: _____