OMB No. 0915-0151
Expires: June 30, 2008

THE RYAN HIV/AIDS PROGRAM
DENTAL SERVICES REPORT

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HRSA
HEALTH RESOURCES AND SERVICES ADMINISTRATION
HIV/AIDS Bureau

Division of Community-Based Programs
HIV/AIDS Bureau
Health Resources and Services Administration
Parklawn Building, Room 7A-30

5600 Fishers Lane
Rockville, Maryland 20857

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Please refer to the Dental Services Report Instructions for a description of each section and item.

All Part F Dental programs must complete Sections 1 through 4. If you are applying for Dental Reimbursement Program (DRP) funding, continue to Section 5. If you are submitting the annual data report for the Community-Based Dental Partnership Program (CBDPP), complete Section 6 instead of Section 5.

SECTION 1. INSTITUTION/PROGRAM AND CONTACT INFORMATION

1. Institution/program information:

Organization _____

Address _____

_____

City _____

State _____ ZIP Code_____

Nine-digit Federal tax ID # ☐☐-☐☐☐☐

☐☐☐ D-U-N-S number: ☐☐-☐☐

☐-☐☐☐☐

Institution/program Web site address: _____

_____

Program Contact Person: This individual will be notified of funding and will be considered the primary contact person for all Dental Program communications.

Name_____

Title/Position_____

Address (if different from address in #1)

_____

_____

City _____

State_____ ZIP Code_____

Telephone: (__ __ __) __ __ __-__ __ __ __

Fax: (__ __ __) __ __ __-__ __ __ __

Pager: (__ __ __) __ __ __-__ __ __ __

E-mail address:_____

2. Is the institution in #1 using this Report to (*select only one*):

- ☐ Apply for funds through the Dental Reimbursement Program (DRP)? (Complete Sections 1 through 5)
- ☐ Submit data for the Community-Based Dental Partnership Program (CBDPP)? (Complete Sections 1 through 4 and 6)

3. Type of institution/program submitting this Report (*select only one*):

- ☐ Accredited predoctoral dental education program—School of Dentistry
- ☐ Accredited postdoctoral dental education program—School of Dentistry, Hospital, Health Center or Other
- ☐ Accredited dental hygiene education program

4. Program contact person (dentist or dental hygienist) most closely connected to the provision of services covered by this Report:

5. ☐ Check this box if the program contact person in #4 would like to receive bimonthly updates from the HIV/AIDS Bureau on technical assistance and primary care related to the Ryan White HIV/AIDS Program.

Bimonthly updates are distributed by email ONLY; therefore, you must specify an e-mail address in #4.

6. Alternate program contact person (this individual will be contacted if the person identified in #4 cannot be reached):

Name_____

Title/Position_____

Address (if different from address in #1)

_____

_____

City _____

State_____ ZIP Code_____

Telephone: (__ __ __) __ __ __-__ __ __ __

Fax: (__ __ __) __ __ __-__ __ __ __

Pager: (__ __ __) __ __ __-__ __ __ __

E-mail address:_____

7. Contact person *(if different from #4)* responsible for verifying and submitting data contained in this Dental Services Report:

The data you provide in this Report, as part of your Federally-supported program, are subject to audit.

Name_____

Title/Position_____

Address (if different from address in #1)

_____

_____

City _____

State_____ ZIP Code_____

Telephone: (__ __ __) __ __ __-__ __ __ __

Fax: (__ __ __) __ __ __-__ __ __ __

Pager: (__ __ __) __ __ __-__ __ __ __

E-mail address:_____

SECTION 2. PATIENT DEMOGRAPHICS AND ORAL HEALTH SERVICES

Note: Throughout this Report, all references to "your program" refer to aggregate data from your institution/program including all your partners or sites, if applicable. Avoid reporting in the "Unknown" category whenever possible.

8a. Total number of unduplicated patients with HIV treated by students, residents, faculty, and other dental staff of your program:

8b. Of the number of patients reported in #8a, how many were seen by your program for the first time during the period covered by this Report?

9. Please show the HIV/AIDS status of the patients reported in #8a (as of the first visit in the period covered by this Report):

HIV/AIDS Status	Number of
HIV-positive, not AIDS	
CDC-defined AIDS (HIV-positive with AIDS-defining illness)	
HIV-positive, AIDS status unknown	
Total	

10. Of the number of patients reported in #8a, indicate the number by gender:

Gender	Number of Patients with HIV
Male	
Female	
Transgender	
Unknown/unreported	
Total	

11. Of the number of <u>female</u> patients with HIV reported in #10, indicate the number by pregnancy status:

Pregnancy Status	Number of Female Patients with HIV
Pregnant	
Not pregnant	
Unsure if pregnant	
Unknown/unreported	
Total	

If unknown/unreported, explain why: _____

_____

12a. Of the number of patients reported in #8a, indicate the number by ethnicity:

Ethnicity	Number of Patients with HIV
Hispanic or Latino/a	
Non-Hispanic or Latino/a	
Total	

12b. Of the number of patients reported in #8a, indicate the number by race:

Race	Number of Patients with HIV
White	
Black or African American	
Asian	
Native Hawaiian or Other Pacific Islander	
American Indian or Alaska Native	
More than one race	
Total	

13. ***Of the number of patients reported in #8a, indicate the number by age:***

Age	Number of Patients with HIV
12 or younger	
13–24	
25–44	
45–64	
65 or older	
Unknown/unreported	
Total	

14. Of the number of patients reported in #8a, indicate the number by household income:

Income	Number of Patients with HIV
Equal to or below the Federal poverty line	
101–200% of Federal poverty line	
201–300% of Federal poverty line	
> 300% of Federal poverty line	
Unknown/unreported	
Total	

15. Indicate the total number of visits made by patients reported in #8a for each type of oral health service:

Type of Service	Number of Visits
Diagnostic	
Preventive	
Oral health education/health promotion	
Nutrition counseling	
Tobacco prevention/cessation	
Oral medicine/oral pathology	
Restorative	
Periodontic	
Prosthodontic	
Oral and maxillofacial surgery	
Endodontic	
Anesthesia/sedation/nitrous oxide analgesia/palliative care	
Emerg0ency services	
Other (specify: _____ _____)	

16. Of the number of patients reported in #8a, please show where they received their primary medical care by each of the following locations:

Location of Primary Medical Care	Number of Patients with HIV
Provider or clinic co-located in the same physical facility or site where oral health care is provided	
Provider or clinic in the same institution providing oral health care, but at a different site	
Other medical provider or clinic not in the same institution providing oral health care, at a different site	
Unknown/unreported	
Total	

SECTION 3. FUNDING AND PAYMENT COVERAGE

17a. Did the parent institution of the program identified in #1 receive any other Ryan White HIV/AIDS Program funding (not only for oral health care or training) during the period covered by this Report?

☐ Yes *(go to #17b)*
☐ No *(go to #18)*

17b. Indicate the total funds the parent institution of the program identified in #1 received from other Ryan White HIV/AIDS Program grants to provide any HIV-related services or training during the period covered by this Report *(rounded to the nearest dollar)*:

Ryan White Program Part	Amount Received
Part A	
Part B	
Part C	
Part D	
Special Projects of National Significance (SPNS)	
AIDS Education and Training Centers (AETCs)	

18. Of the number of patients reported in #8a, indicate the number whose third party coverage for oral health services fell under each of the following categories:

Third Party Payor Coverage	Number of Patients with HIV
Number of patients who received oral health care with **NO third party payor coverage**	
Number of patients who received oral health care with **PARTIAL third party payor coverage**	
Number of patients whose third party payor coverage status was **UNKNOWN**	

19. Indicate the number of patients with HIV whose oral health care was partially covered by each of the following sources and the total amount of payment received (rounded to the nearest dollar):

Payment Source	Number of Patients with HIV	Payment Received ($)
Medicaid (non-HMO/ non-managed care)		
Medicaid (HMO/managed care)		
Medicare		
Other public insurance (e.g., TRICARE, VA)		
Private insurance, including HMO/managed care		
Self-pay or cash		
Other (specify: _____ _____)		
Unknown		

SECTION 4. STAFFING AND TRAINING

20. ***For the period covered by this Report, provide the following information about the number of dental students, residents, dental hygiene students, and other non-student dental providers who participated in or rotated through your program. Please feel free to attach an optional narrative description of your HIV training program as further clarification of the information that you provide below.***

	Predoctoral Dental Students	Dental Residents or Postdoctoral Students	Dental Hygiene Students	Other Non-Student Dental Providers
a. The total number of students and residents who were enrolled in all years of your school or program				
b. The total number of students, residents, and other providers who received formal didactic instruction in medical assessment or oral health management for patients with HIV				
c. The total number of students, residents, and other providers who gained experience providing direct clinical services for patients with HIV				
d. The total number of hours of your training curriculum (didactic and clinical combined) that were dedicated to issues related to medical assessment or oral health management for patients with HIV				
i. As part of required curriculum	i. _____	i. _____	i. _____	
ii. As part of elective curriculum	ii. _____	ii. _____	ii. _____	ii. _____
e. The total number of hours that all students, residents, and other providers spent providing direct clinical services for patients with HIV				

Continue with Section 5 if you are applying for DRP funding. Otherwise, skip to Section 6 if you are submitting an annual CBDPP data report.

SECTION 5. ADDITIONAL DENTAL REIMBURSEMENT PROGRAM INFORMATION

21. Person authorized to sign for the institution:

Name_____

Title/Position_____

Address (if different from address in #1)

_____

_____

City _____

State_____ ZIP Code_____

Signature _____

A. USE OF FUNDING

22. Specify how the Dental Reimbursement funds will be used within your predoctoral dental/postdoctoral dental/dental hygiene education program *(check all that apply)*:

- ☐ Direct patient services (e.g., provider/faculty salaries)
- ☐ Patient education or outreach
- ☐ Curriculum development
- ☐ Student education/training
- ☐ Staff education/training
- ☐ Clinic staff salary/support
- ☐ Equipment/instruments/supplies/materials
- ☐ Pharmaceuticals or dental medicaments
- ☐ General operations
- ☐ Other (specify:_____)

B. UNREIMBURSED COSTS

23a. Total unreimbursed costs of oral health care provided to patients with HIV (*rounded to the nearest dollar)*:

$

Submit responses to #23b through #28 as separate attachments.

23b. As a separate attachment, please provide a concise description of the methods used to calculate the amount reported in #23a.

C. NARRATIVES

24. Site Descriptions

List and concisely describe the sites where your predoctoral dental/postdoctoral dental/dental hygiene education program provides oral health services to patients with HIV. In identifying these sites, please address the following questions:

- Do your students or residents provide direct patient care in community-based facilities?
- Are such facilities organizational components of your institution, or are they separate organizations?

25. Working Relationships with Ryan White HIV/AIDS Programs

Concisely describe working relationships that your predoctoral dental/postdoctoral dental/dental hygiene education program has established with the Ryan White HIV/AIDS Programs listed in item #17b, including Part A HIV Planning Councils and Part B HIV Consortia. Describe how your program has been working to maximize coordination, integration, and effective linkages among local Ryan White HIV/AIDS Programs.

26. Development of the Statewide Coordinated Statement of Need

Concisely describe how your predoctoral dental/postdoctoral dental/dental hygiene education program has been involved in the development and updating of the Statewide Coordinated Statement of Need (SCSN) in your state.

27. Outreach

Concisely describe any additional ways your predoctoral dental/postdoctoral dental/dental hygiene education program conducts outreach to persons with HIV to increase their awareness of the availability of oral health services, or builds community links with program managers and providers working with this population.

28. Special Strengths or Unique Capabilities

Concisely describe any special strengths or unique capabilities of your predoctoral dental/postdoctoral dental/dental hygiene education program in providing oral health care for patients with HIV (e.g., facilities, hours of operation, support services, or staff skills or expertise). Responses might include information regarding evening and weekend clinic hours, onsite participation in clinical trials, provider or staff diversity, special patient education programs, the availability of childcare services, language translation services, transportation services, or other special strengths.

Section 6 should be completed only by CBDPP grantees.

SECTION 6. ADDITIONAL COMMUNITY-BASED DENTAL PARTNERSHIP PROGRAM INFORMATION

29. List the names and addresses of the member organizations of your Community-Based Dental Partnership Program (other than your institution) and their roles or function in the partnership.

Name of Partner Organization	Contact Information	Does partner receive CBDPP funds?	Brief Description of Partner's Role or Function
	Street: ______ City: ______ State: ______, ZIP ______ Phone: ______ Fax: ______ Contact Person ______ Contact Email Address: ______	Yes ☐ No ☐	
	Street: ______ City: ______ State: ______, ZIP ______ Phone: ______ Fax: ______ Contact Person ______ Contact Email Address: ______	Yes ☐ No ☐	
	Street: ______ City: ______ State: ______, ZIP ______ Phone: ______ Fax: ______ Contact Person ______ Contact Email Address: ______	Yes ☐ No ☐	
	Street: ______ City: ______ State: ______, ZIP ______ Phone: ______ Fax: ______ Contact Person ______ Contact Email Address: ______	Yes ☐ No ☐	

If space for more partners is needed, please copy this page and complete as many boxes as needed.

30. Indicate which of the following populations were specially targeted to receive services through the Community-Based Partnership Program (check all that apply):

- ☐ Urban populations
- ☐ Suburban populations
- ☐ Rural populations other than migrant or seasonal workers
- ☐ Migrant or seasonal workers
- ☐ Runaway or street youth
- ☐ Gay, lesbian, bisexual, transgender youth
- ☐ Gay, lesbian, bisexual, transgender adults
- ☐ Homeless persons
- ☐ Incarcerated persons
- ☐ Paroled persons
- ☐ Substance addicted persons
- ☐ Other, specify: _____