



# INSTRUCTIONS FOR COMPLETING THE RYAN WHITE HIV/AIDS PROGRAM DENTAL SERVICES REPORT



Division of Community-Based Programs  
HIV/AIDS Bureau  
Health Resources and Services Administration  
Parklawn Building, Room 7A-30  
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Rockville, Maryland 20857

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## FORM OVERVIEW

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The Dental Services Report is used by two different programs under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program): the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP).

The Report is designed to collect data from accredited pre- and post-doctoral dental education programs and dental hygiene education programs regarding oral health services provided to people who are HIV positive.

Institutions applying for Dental Reimbursement funding may submit a completed Report annually to receive assistance with their unreimbursed costs of care incurred in providing direct oral health services. CBDPP grant recipients use this Report to submit annual program data, which is a condition of their grant awards.

### **Public Burden Statement**

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0151. Public reporting burden for the applicant for this collection of information is estimated to average 20 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to:

HRSA Reports Clearance Officer  
5600 Fishers Lane, Room 14-45  
Rockville, Maryland, 20857

# OVERVIEW OF THE RYAN WHITE HIV/AIDS DENTAL PROGRAMS

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## Introduction

Section 2692(b) of Title XXVI of the Public Health Service Act authorizes the Secretary of Health and Human Services to make grants through the Dental Reimbursement Program (DRP) to accredited predoctoral dental, postdoctoral dental, and dental hygiene education programs to help cover the unreimbursed costs of providing oral health services to patients with HIV. Each eligible dental education program may submit an annual application that documents its unreimbursed costs of providing oral health care to patients with HIV during the prior year. The Secretary distributes the available funds among all eligible applicants, taking into account the unreimbursed costs incurred by each institution, the total of all costs incurred by all eligible applicants, and the amount of funds available.

Section 2692(b) also authorizes the Secretary to make grants to accredited predoctoral dental, postdoctoral dental, and dental hygiene education programs, to support partnerships between dental education programs and community-based oral health providers. The Community-Based Dental Partnership Program (CBDPP) focuses on the provision of care and the training of additional oral health providers through collaborative community-based partnerships, to increase access to oral health care for people with HIV. The CBDPP grants are awarded for project periods up to five years. Each grantee must collect, manage, and report annual program data that will document key service delivery and educational components of the funded programs.

## Administration

The HIV/AIDS DRP and the CBDPP are administered by the Division of Community-Based Programs within the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). Questions regarding these programs should be directed to:

Mahyar Mofidi, D.M.D., Ph.D.  
Telephone: 301-443-2075  
Division of Community-Based Programs  
HIV/AIDS Bureau, HRSA  
Parklawn Building, Room 7A-30  
5600 Fishers Lane  
Rockville, MD 20857

## Eligibility

To be eligible for DRP and CBDPP funding, the applicant must be an institution with a predoctoral dental, postdoctoral dental or dental hygiene education program that is accredited by the Commission on Dental Accreditation of the American Dental Association. DRP applicants must have documented unreimbursed costs of oral health care provided to persons with HIV.

# REQUIREMENTS AND METHODS FOR SUBMISSION

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## General Requirements

All programs must complete Sections 1 through 4 of the Dental Services Report, which includes:

- Institution/Program and Contact Information
- Patient Demographics and Oral Health Services
- Funding and Payment Coverage
- Staffing and Training

The requested data must be submitted in the Office of Management and Budget (OMB) approved format.

## Dental Reimbursement Program Application Requirements

All applicants for DRP funding will use this Report to submit information for the period **July 1 through June 30** of the previous year (e.g., applications due in Spring/Summer 2008 report on services and training provided from July 1, 2006 to June 30, 2007).

In addition to Sections 1 through 4, DRP applicants also must complete Section 5, which includes items regarding funding, payment coverage sources, and narratives. The narrative responses describe various aspects of the applicant's program, and help portray the scope of oral health care provided to patients with HIV.

A Payment Information Form must be completed and mailed to WRMA/CSR at the address given below if you have not previously applied for DRP funding, or if information contained in the last Payment Information Form submitted has changed (e.g., your institution's Federal tax ID number, or bank routing or account information).

## Submission and Due Date

**To be considered for DRP funding, applications must be received no later than June 23, 2008.**

You are strongly encouraged to use the Database Utility provided to complete and submit your Report electronically.

If you choose to submit an application on paper, it is preferable that you fax your Report to the WRMA/CSR fax number shown below, or you

may express mail your completed original Report plus TWO copies (and a completed Payment Information Form, if applicable) to:

WRMA/CSR Ryan White Project  
Attn: Dental Services Report  
2107 Wilson Blvd, Suite 1000  
Arlington, VA 22201  
FAX: (703) 312-5230

DRP applications received after the due date, incomplete applications, and applications from institutions that do not have an accredited dental or dental hygiene education program, **WILL NOT BE ACCEPTED FOR CONSIDERATION FOR DENTAL REIMBURSEMENT PROGRAM FUNDING.**

## Community-Based Dental Partnership Program Data Reporting Requirements

All CBDPP grantees will use this Report to submit annual program data for the period of **January 1 through December 31** of the prior year. The CBDPP Reports are typically due in March each year.

In addition to Sections 1 through 4, CBDPP grantees must also complete Section 6, which includes items about the community-based partnership and target populations.

**You are strongly encouraged to use the Database Utility provided to complete and submit your Report electronically. If you choose to submit an annual data report on paper, you may fax your Report to the WRMA/CSR fax number shown above, or you may mail your completed original Report plus TWO copies to the address shown above.**

### **Dental Services Report Assistance**

If you need additional copies of materials for your paper submissions, go to the HIV/AIDS Bureau Web site at <http://hab.hrsa.gov/tools.htm> to view and download the Dental Services Report, Instructions for Completing the Report, and the annual cover letter and related materials (and Payment Information Form, for DRP applicants only).

WRMA/CSR offers technical assistance via telephone and e-mail to DRP applicants and CBDPP grantees.

### **Ryan White HIV/AIDS Program Data Support Help Line**

Hours of operation: 9:00 a.m. to 5:30 p.m. ET

Days of operation: Monday through Friday

Phone Number: 1-888-640-9356

(through July 3, 2008)

E-mail:

[RWdatasupport.wrma@csrincorporated.com](mailto:RWdatasupport.wrma@csrincorporated.com)

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# DENTAL SERVICES REPORT INSTRUCTIONS

*All programs must complete Sections 1 through 4 (Items #1- 20).*

## SECTION 1. INSTITUTION/PROGRAM AND CONTACT INFORMATION

### Item #1. Institution/Program Information

Enter the institution or program name and the address. Please remember to indicate the institution's Federal tax identification number and DUNS number. If available, enter a Web site address for the organization indicated in the first line.

### Item #2. Purpose of This Report

Indicate whether the institution identified in item #1 is applying for DRP funding, or submitting annual CBDPP data. **Note:** *Institutions that are applying for DRP funding and have a CBDPP grant must submit separate Reports reflecting the separate patient populations served by the DRP and the CDBPP.*

Applicants for DRP funding will submit information for the period **July 1 through June 30** of the previous year (e.g., applications due in 2008 report on services and training from July 1, 2006 to June 30, 2007). CBDPP grantees will submit annual program data for the period of **January 1 through December 31** of the prior year.

### Item #3. Type of Institution/Program

Indicate the type of education program submitting this Report (select only 1 option).

### Item #4. Program Contact Person

Indicate the name and contact information for the person most closely connected to the provision of services covered by this Report, typically the dentist or dental hygienist managing the program. This individual will be notified of funding and will be considered the primary contact person for all Dental Program communications. Please indicate the contact person's e-mail address, as this has become a primary method of correspondence.

### Item #5. Program Updates

Check the box if the person identified in item #4 would like to receive bimonthly e-mail updates

from the HIV/AIDS Bureau. If this box is checked, an e-mail address must be provided in item #4.

1

### Item #6. Alternate Program Contact

Provide the name and contact information for an alternate contact person connected to the provision of services if the person identified in item #4 cannot be reached.

1

### Item #7. Data Contact Person

Provide the name and contact information for the person responsible for verifying the data and submitting this Report, if different from the person listed in item #4. The individual listed in this Item will be contacted if there are questions about the data submitted in this Report. Please indicate "same person as in item #4" on the "name" line, if that is the case.

*Reporting demographic information about patients receiving care supported by Ryan White HIV/AIDS Program funds (as requested in items #8 – #16) is a program requirement of all Ryan White HIV/AIDS Program grant recipients. Demographic information is based on patients' self-identification.*

*All references to "your program" refer to aggregate data from your institution/program, including all partners or sites, if applicable.*

*Please avoid reporting in the "unknown" category whenever possible.*

## SECTION 2. PATIENT DEMOGRAPHICS AND ORAL HEALTH SERVICES

### Item #8a. Unduplicated Patient Count

Indicate the number of all unduplicated patients with HIV who received *at least one oral health service* from the students, residents, faculty, or dental staff of your program during the period covered by this Report, regardless of where these services were provided. This number should include all individuals who are HIV positive seen during this period, **regardless of the funding sources that supported their care.** Include patients who are not continuing to receive services

from your clinic because they moved, transferred to another institution, program, or provider; or died.

This must be an actual count of patients with HIV. You may not use estimates of any kind.

#### Item #8b. New Patients

Of the number of patients reported in item #8a, indicate how many patients were seen by your program for the first time during the period covered by this Report. Patients, who were seen in a prior period, even if after an absence from your clinic, should not be counted as new patients.

**Note:** The number of new patients provided in item #8b must be less than or equal to the total in item #8a.

#### Item #9. HIV/AIDS Status

Of the number of patients reported in item #8a, indicate the number by HIV/AIDS status as of the first visit in the period covered by this Report.

**Note:** The sum of all HIV/AIDS status categories must equal the total number of patients reported in item #8a.

#### The 1993 AIDS Surveillance Case Definition of the U.S. Centers for Disease Control and Prevention <sup>\*1</sup>

A diagnosis of AIDS is made whenever a person is HIV-positive and:

- He or she has a CD4+ cell count below 200 cells per microliter;
- His or her CD4+ cells account for less than 14 percent of all lymphocytes; OR
- That person has been diagnosed with one or more AIDS-defining illnesses.

Go to <http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm> for a complete list.

#### 1Item #10. Gender

Of the number of patients reported in item #8a, indicate the number by gender. **Note:** The sum of all gender categories must equal the total number of patients reported in item #8a.

1

#### 2Item #11. Pregnant Patients

Of the total number of female patients with HIV reported in item #10, indicate their pregnancy status during the period covered by this Report. Indicate their status as “pregnant,” when that is known, regardless of the outcome of the pregnancy. Also, indicate the number who were known not to be pregnant, or who were unsure of their pregnancy status. **Note:** If data are reported

in the “unknown/unreported” category, indicate why the data are not available. The sum of all pregnancy categories must equal the total number of female patients reported in item #10.

#### Item #12a. Ethnicity

Of the number of patients reported in item #8a, indicate the number by the ethnicity categories shown. **Note:** The sum of the ethnicity categories must not exceed the total number of patients reported in item #8a. Ryan White HIV/AIDS Program dental programs are expected to make every effort to obtain and report ethnicity information, based on each patient’s self-identification.

Hispanic or Latino/a is a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

#### Item #12b. Race

Of the number of patients reported in item #8a, indicate the number by the race categories shown. Patients who identify with more than one race or as being of mixed race should be counted in the “More than one race” category.

**Note:** The sum of all race categories must not exceed the total number of patients reported in item #8a. Ryan White HIV/AIDS Program dental programs are expected to make every effort to obtain and report race information, based on each patient’s self-identification.

The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget (For more information see [www.whitehouse.gov/omb/fedreg/ombdir15.html](http://www.whitehouse.gov/omb/fedreg/ombdir15.html)). HRSA mandated use of these categories as of January 2002.

*White* is a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

*Black or African American* is a person having origins in any of the black racial groups of Africa.

*Asian* is a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

*Native Hawaiian or Other Pacific Islander* is a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

*American Indian or Alaska Native* is a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

*More than one race* is a person who identifies with more than one racial category.

### 1Item #13. Age

Of the number of patients reported in item #8a, indicate the number of patients by their oldest ages at any time during the period covered by this Report. **Note:** *The sum of all age categories must equal the total number of patients reported in item #8a.*

1

### 2Item #14. Household Income

Of the number of patients reported in item #8a, indicate the number of patients by their annual household income relative to the Federal poverty guidelines, at any time during the period covered by this Report. (See Poverty Guidelines, Research, and Measurement at:

<http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>.)

**Note:** *The sum of all Household Income categories must equal the total number of patients reported in item #8a.*

1

2

### 3Item #15. Types of Oral Health Services

*Instructions for Completing the Ryan White HIV/AIDS Program 2008 Dental Services Report*

Indicate the total number of visits made by patients reported in item #8a for each type of service provided during the period covered by this Report. The intent of this question is to determine the scope and relative frequency of oral health services provided for your patients, not the number of individual treatment procedures performed. Therefore, for purposes of this Report, please **report numbers of visits**, not patients or procedures. As far as possible, if your program provided several services during a single clinic visit, count each service type as a separate visit. For example, if during a patient's visit to the clinic, you took radiographs, performed two quadrants of root planing, and provided root canal therapy for two molars, please count these as three visits, that is, one visit each in the diagnostic, periodontic, and endodontic service categories.

If the type of service provided is not listed on the form, specify it in the "Other" category.

1

### 2Item #16. Location of Primary Medical Care

Of the number of patients reported in item #8a, show the number who usually received their primary medical care in each of the locations shown. **Note:** *The total number of patients reported here should be equal to the total reported in item #8a.*

## SECTION 3. FUNDING AND PAYMENT COVERAGE

### Item #17a. Ryan White HIV/AIDS Program Funding

Indicate whether or not the parent institution of the program identified in item #1 received any other Ryan White HIV/AIDS Program funding during the period covered by this Report (i.e., monies received from Parts A-B, Special Projects of National Significance, or AIDS Education and Training Centers), to provide any HIV-related services, not only oral health services, or training. If the answer is "Yes," complete item #17b, otherwise continue with item #18.

### Item #17b. Ryan White HIV/AIDS Program Funding Amounts

Indicate the total amount the parent institution of the program identified in item #1 received from each of the Ryan White HIV/AIDS Programs listed (rounded to the nearest dollar).

1

2

3

### 4Item #18. Third Party Payor Coverage

Note: Only direct payments from third party payors (public and private), for services provided should be reported in items #18 and #19. For the purposes of this Report, funding from Ryan White HIV/AIDS Program or other grants is considered program income or revenue, and should not be reported in items #18 or #19.

Of the number of patients reported in item #8a, indicate how many received oral health care with no or partial third party payor coverage, and the number whose third party payor coverage status was unknown. **Note:** *The total number of patients reported here should be equal to the total reported in item #8a.*

**1**  
**2Item #19. Number of Patients and Payments Received**

Indicate the number of patients with HIV whose oral health care was partially covered by each of the indicated payment sources and the amount of payments received (rounded to the nearest dollar) from those sources, including patients who self-pay. For the purposes of this Report, count a patient in this table if at any time during the period covered by this Report, payment was received for at least one visit or service.

Patients whose oral health care was covered by more than one payment source should be reported under **all** categories of payment source from which payment was received. For example, a patient whose care was supported by Medicare and private insurance should be reported twice in this table. If a particular payment source is not included on the form, specify it in the “Other” category.

**SECTION 4. STAFFING AND TRAINING**

**1**  
**2Item #20. Staffing and Training**

For the period covered by this Report, indicate the total number of students, residents, and other non-student dental providers who were enrolled in or rotated through your program, and the total number of those students, residents, and other dental providers who received training in providing services to patients with HIV. Also indicate the total number of hours of your training curriculum dedicated to issues related to HIV and oral health management, and the total number of hours that all students, residents, and other dental providers spent providing direct clinical services for patients with HIV. Please feel free to attach any optional

narrative description of your HIV training program if you wish to provide further clarification.

**SECTION 5. ADDITIONAL DENTAL REIMBURSEMENT PROGRAM INFORMATION**

*This section should only be completed by institutions applying for DRP funding.*

**1**  
**2Item #21. Authorized Signature**

Indicate the name and contact information for the person authorized to sign for the institution.

**A. USE OF FUNDING**

**1**  
**2Item #22. Intended Use of DRP Funds**

Check each option for the ways in which Dental Reimbursement funds will be used. If a particular use is not listed, specify it in the “Other” category.

**B. UNREIMBURSED COSTS**

**Item #23a. Total Unreimbursed Costs**

Indicate the total unreimbursed costs (rounded to the nearest dollar) of oral health care provided to patients with HIV during the period covered by this Report. Institutions/programs should review their charts and financial records to calculate total actual unreimbursed costs of services provided. If actual costs cannot be calculated, then use as a surrogate the applicant institution’s usual fees for the services provided (before any discount or sliding-fee schedule is applied).

**Item #23b. Calculation Methods**

Please provide, as a separate Word attachment, a concise description of the methods used to calculate the amount reported in item #23a.

**C. NARRATIVES**

If submitting on paper, please e-mail your narrative responses as a separate Word attachment. If submitting electronically, you may enter (or copy and paste) your responses directly into the database utility.

Your narrative responses will inform HRSA of your program’s unique characteristics and strengths in providing comprehensive oral health care for patients with HIV. Your responses will also enable HRSA to more fully understand the environment in which oral health care is provided to patients with HIV, and to gauge the extent of

collaboration among the various Ryan White HIV/AIDS Program-supported programs.

1

#### **2Item #24. Site Descriptions**

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, describe whether students and residents provide direct patient care in community-based facilities, and whether such facilities are organizational components of your institution or separate organizations.

1

#### **2Item #25. Working Relationships with Ryan White HIV/AIDS Programs**

Describe working relationships that your predoctoral dental/postdoctoral dental/dental hygiene education program has established with 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 Program-funded programs.

1

#### **2Item #26. Development of the Statewide Coordinated Statement of Need**

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). Include direct and indirect involvement with your state's SCSN.

1

#### **2Item #27. Outreach**

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.

1

#### **2Item #28. Special Strengths or Unique Capabilities**

Concisely describe any special strengths or unique capabilities of your predoctoral dental/postdoctoral dental/dental hygiene education program with respect to 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. ADDITIONAL COMMUNITY-BASED DENTAL PARTNERSHIP PROGRAM INFORMATION**

This section should be completed only by CBDPP grantees.

1

#### **2Item #29. Partnership Program Information**

In the table provided, list the names and addresses of the member organizations of your Community-Based Dental Partnership Program, and each partner's primary contact person. Also indicate if each partner receives CBDPP funds, and briefly describe each partner's role, function, or contribution to the partnership (e.g., special staff skills, capacity to provide services or train providers, experience managing grants, expertise in community outreach or dental case management, capacity to provide transportation or child care services, etc.).

1

#### **2Item #30. Target Populations**

Indicate which populations were specially targeted to receive outreach or services from your program during the period covered by this Report.

*Note: Ryan White HIV/AIDS Program funds may only be used for limited short-term, transitional social support and primary care services for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning. Please consult "HAB Policy Notice – 01-01 of July 23, 2001" for further clarification of the limitations on the use of Ryan White HIV/AIDS Program funds to provide services to incarcerated persons.*

## GLOSSARY OF TERMS

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<b>Eligible Applicant</b>	A dental school or other institution with a predoctoral or postdoctoral dental education program, or a dental hygiene education program, that has provided oral health care for patients with HIV and has been accredited by the Commission on Dental Accreditation.
<b>Household income</b>	The sum of money received in the previous calendar year by all household members, ages 15 years and older, including household members not related to the householder, people living alone, and others in nonfamily households.
<b>Patient with HIV</b>	A person who has the human immunodeficiency virus; a person with documented confirmation of her/his positive serostatus [examples include a positive HIV test result; a letter verifying that the person is receiving HIV-related care or services from a primary medical care provider, case manager, AIDS service organization; a viral load test result; an ADAP (AIDS Drug Assistance Program) enrollment card and similar documents]; or a person who self-identifies as being HIV positive.
<b>Period Covered by this Report</b>	The period for which you are reporting data. If you are applying for DRP funding, this Report should present data on services provided from July 1 through June 30 of the prior year. If you are submitting an annual CBDPP data report, this Report should present data on services provided from January 1 through December 31 of the prior year.
<b>Ryan White HIV/AIDS Program</b>	<i>The Ryan White HIV/AIDS Treatment Modernization Act of 2006</i> —The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWHA) disease and their families in the United States and its Territories. The newly enacted law changes how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS.
<b>Statewide Coordinated Statement of Need (SCSN)</b>	A statement of significant HIV-related issues specific to each state, which is a result of coordination, integration, and effective links across the Ryan White HIV/AIDS Programs. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 requires grantees to conduct activities to enhance coordination across all Ryan White HIV/AIDS Programs, including collaborative development of a SCSN.
<b>Unduplicated Number of Patients</b>	Patients counted using a method by which a single individual is counted only once during the period covered by this Report, regardless of how many clinic visits were made or procedures performed. For institutions that provided care at multiple sites, a patient is counted only once, even if he or she received services at more than one site.
<b>Unreimbursed Oral Health Care Costs</b>	The balance remaining after subtracting the total payment received from patients with HIV or Medicaid or other third-party payers, plus grants and all other sources of revenue to support oral health care for HIV positive patients, from the total of actual costs incurred by the applicant institution in providing oral health care to those patients. If actual costs to provide services cannot be calculated, then the applicant institution's usual fees for those procedures (before any discount or sliding-fee schedule is applied) should be used as a surrogate for actual costs.