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THE RYAN HIV/AIDS PROGRAM
DENTAL SERVICES REPORT

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources and Services Administration
Parklawn Building, Room 9-74
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.

SECT ION 1. INSTITUTION/PROGRAM AND CONTACT INFORMAT ION

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: _____

_____

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:

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

Email address: _____

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

Name _____

Title/Position _____

Address (if different from address in #1)

_____

_____

City _____

State _____ Zip Code _____

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

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

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

Email address: _____

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

Email address: _____

SECT ION 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.

7a. Total number of unduplicated patients with HIV treated by students, residents, faculty, and other dental staff of your program:

7b. Of the number of patients reported in #7a, how many were seen by your program for the first time during the period covered by this Report?

8. Please show the HIV/AIDS status of the patients reported in #7a (as of the first visit in the period covered by this Report):

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

9a. Of the number of patients with HIV reported in #7a, indicate the number by gender:

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

9b. Of the number of patients with HIV reported in #7a, indicate the number by the sex assigned to the clients at birth:

Sex at Birth	Number of Patients with HIV
Male	
Female	
Total	

10. Of the number of female patients with HIV reported in #9b, indicate the number by pregnancy status:

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

11a. Of the number of patients with HIV reported in #7a, indicate the number by ethnicity:

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

11b. Of the number of Hispanic patients with HIV reported in #11a, indicate the number by ethnic group. The total number reported here must equal the number of Hispanic or Latino/a patients reported in #11a:

Ethnicity	Number of Patients with HIV
Mexican, Mexican American, Chicano/a	
Puerto Rican	
Cuban	
Other Hispanic, Latino/a or Spanish origin	
Total	

12a. Of the number of patients with HIV reported in #7a, 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	

12b. Of the number of Asian patients with HIV reported in #12a, indicate the number by racial group. The total number reported here must equal the number of Asian patients reported in #12a:

Asian Race	Number of Patients with HIV
Asian Indian	
Chinese	
Filipino	
Japanese	
Korean	
Vietnamese	
Other Asian	
Total	

12c. Of the number of Native Hawaiian or other Pacific Islander patients with HIV reported in #12a, indicate the number by racial group. The total number reported here must equal the number of Native Hawaiian or other Pacific Islander patients reported in #12a:

Native Hawaiian/Pacific Islander Race	Number of Patients with HIV
Native Hawaiian	
Guamanian or Chamorro	
Samoan	
Other Pacific Islander	
Total	

13. Of the number of patients with HIV reported in #7a, 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 with HIV reported in #7a, 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 #7a for each type of the following 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	
Emergency services	
Other (specify: _____ _____)	

Location of Primary Medical	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	

16. Of the number of patients with HIV reported in #7a, please show where they received their primary medical care by each of the following locations:

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 (including Part A MAI)	
Part B (including Part B MAI)	
Part C	
Part D	
Special Projects of National Significance (SPNS)	
AIDS Education and Training Centers (AETCs)	

18. Of the number of patients reported in #7a, 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	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 Program 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)*:

$

23b. 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. 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. ADDITIONAL COMMUNITY-BASED DENTAL PARTNERSHIP PROGRAM INFORMATION

27. 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.

28. 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: _____