NEW 2026 APPLICATION

03/01/2026

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 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 (2026: $79,800; add $28,400 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 • EMAIL rwdp@bphc.org

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 Policies** -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 $79,800.00 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, email, or fax.

03/01/2026

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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 my current dental provider: ____ 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)

PAGE 2/4 REQUIRED TO SUBMIT

Ryan White Dental Program Client Enrollment Form

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) I would like my approval letter sent to (select 1):
☐ My mailing address
☐ My email address
☐ My case manager

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): ____

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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 ☐ Perinatal ☐ 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

Last dental provider: ____ **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

PAGE 4/4 REQUIRED TO SUBMIT

RYAN WHITE DENTAL PROGRAM (RWDP) POLICIES ACKNOWLEDGEMENT

COVER PAGE: RWDP POLICIES

As part of the Ryan White Dental Program (RWDP) Client Application process, you must acknowledge the policies of the RWDP and agree to uphold your responsibilities as a client to enroll and maintain eligibility with the program. The explanation of these policies is explained in the following pages. You must submit this form to RWDP, but you may keep an additional copy for your own records.

If you refuse or fail to acknowledge the policies or initial and sign any portion of this cover page (see below), this will affect your eligibility to receive services from the Ryan White Dental Program and furthermore, RWDP cannot reimburse any treatment completed by a contracted dentist.

_____________ **(Initial required) Section A: Client Rights**

_____________ **(Initial required) Section B: Client Right to Refusal Policy**

_____________ **(Initial required) Section C: Client Responsibilities**

_____________ **(Initial required) Section D: Dental Provider/RWDP Right to Refusal Policy**

_____________ **(Initial required) Section E: Confidentiality**

_____________ **(Initial required) Section F: Policy on Grievance Procedure**

Client Signature:____Date:________________

Client Name
(Printed):____Date:________________

This acknowledgment of RWDP policies will expire after 1 year. You will need to **reacknowledge, initial, and sign this form on an annual basis for the Ryan White Dental Program to confirm your eligibility**.

RYAN WHITE DENTAL PROGRAM (RWDP) POLICIES ACKNOWLEDGEMENT

CLIENTS – KEEP THIS COPY FOR YOUR RECORDS

SECTION A: CLIENT RIGHTS

As a client enrolled in the Ryan White Dental Program, you possess the following rights:

1. Confidentiality: You have the right to confidentiality regarding your dental care, medical care, and protected health information as detailed in the RWDP Confidentiality clause.
2. Referrals: You have the right to be referred to any RWDP dental provider while active with the program at the time of the request.
3. Client Records: You have the right to be informed about your client records with RWDP, including, but not limited to, details of your application, treatment plans reviewed by RWDP, dental claims reimbursed by RWDP on your behalf to a RWDP provider, and communication details between RWDP staff and your dental provider.
4. Requirements: You have the right to be informed about any RWDP eligibility requirements, which you must meet to maintain eligibility with RWDP.
5. Fair Treatment: You have the right to fair treatment and to not be discriminated against by RWDP regardless of your race, ethnicity, national origin, sex, sexual orientation, gender identity, age, disability, and other protected classes.
6. Grievances: You have the right to file a grievance, without retaliation for doing so, against a RWDP provider on the basis of poor treatment, substandard care, or discrimination you have experienced. In the event of extreme dissatisfaction, please call RWDP for a resolution or a new referral.
    a. If desired or if you have not received a satisfactory resolution from your filed grievance, you may also escalate your grievance further and request to consult the RWDP Director. If you have not received a satisfactory resolution after these attempts, your grievance may be addressed to the Infectious Disease Bureau Director of the Boston Public Health Commission.

By initialing Section A on the Cover Page: RWDP Policies, you agree to the above declared rights and acknowledge that RWDP will adhere to protecting these outlined rights.

RYAN WHITE DENTAL PROGRAM (RWDP) POLICIES ACKNOWLEDGEMENT

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SECTION B: CLIENT RIGHT TO REFUSAL POLICY

At any point in time, clients have the right to refuse the following certain actions:

1. Service Refusal: You have the right to refuse any services, or terminate your RWDP coverage, without retaliation. Upon your service refusal, or terminating your coverage, you will be informed appropriately about the availability of other dental access programs, contingent upon your consent. Thereafter, your client records will be archived up to the maximum allowable years in accordance with RWDP grant obligations. If you choose to refuse any services, or terminate your RWDP coverage, provided by RWDP, you accept all financial responsibility for paying any out of pocket, or by transferring responsibility to a third-party payor, for any costs associated with services provided by your RWDP dental provider. As such, payments from RWDP for services provided by your RWDP dental provider will be ceased.
2. Referral Refusal: You have the right to refuse any referral to an RWDP provider. Upon request, you may be offered a referral to another dental provider or be informed about other dental access programs, if RWDP dental providers do not meet your expectations.
3. Dental Care Refusal: You have the right to refuse any dental care or dental treatment plan proposed by your dental provider. Your refusal of care will not impact your eligibility with RWDP. However, by refusing any dental care or dental treatment plan, you accept the risks of non-treatment, alternative treatment, or delayed treatment. By refusing any dental care or dental treatment plan, you also agree that RWDP will not be held responsible for any damages or injuries caused by your refusal to any dental care, or dental treatment plan. Furthermore, you agree to consult your dental provider for clinical advice.

By initialing Section B on the Cover Page: RWDP Policies, you acknowledge that you have read your right to refuse the above specifically stated scenarios and accept the consequences and risks associated with the above-mentioned should you choose to employ your right to refuse.

RYAN WHITE DENTAL PROGRAM (RWDP) POLICIES ACKNOWLEDGEMENT

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SECTION C: CLIENT RESPONSIBILITIES

You acknowledge and agree that you must comply with certain actions that are required by the RWDP grant obligations. By Refusing to comply with any grant obligation requirements, RWDP may deem you ineligible for services and discharge you from the program. To be enrolled in RWDP, you agree to uphold your client enrollment responsibilities, which are explained below, and acknowledge the consequences of non-compliance.

1. True and Accurate Information: You attest that you have provided true and accurate information in your application and verification documents regarding your diagnosis, income, home address, health insurance, and dental insurance to the best of your knowledge.
2. Necessary Documents: You acknowledge that you are responsible for providing all necessary documents for your (re-)enrollment. You acknowledge that any missing documentation will lead to your application being deemed incomplete. RWDP reserves the right to deem you ineligible or inactive due to incomplete applications.
3. Eligibility Confirmation: You must confirm your eligibility with RWDP before scheduling any appointment with a contracted dental provider by calling 617-534-2344 or receiving an approval letter or other written communication, such as email.
4. Participation Confirmation: Referrals must come directly from RWDP staff members. RWDP cannot reimburse any care by dentists outside of our network.
5. Maintain Eligibility: You must maintain your eligibility if you wish for your treatment to be reimbursed by RWDP. If your coverage lapses for a period of time, you must work promptly with RWDP staff to provide the necessary documentation to renew your coverage. Otherwise, if you do not recertify in a timely manner, you accept that you will not be eligible for RWDP services until a complete app has been received and processed.
6. Appointments: You must show up on time for your scheduled dental appointments. You must report any emergencies, re-scheduling, or cancellations, to your dental provider directly within twenty-four (24) hours of your scheduled appointment. You acknowledge

that you may be charged additional penalties / fees from the dental provider for any no-call, no-shows, lateness, or failure to report any emergencies or cancellations of your scheduled appointment. Additionally, you acknowledge that RWDP will not reimburse clients for any associated fees or penalties of a no-call, no-show, lateness, or failure to report any emergencies, re-schedule, or cancellations of your scheduled appointment.

7. Proof of Income: You must provide true and accurate proof of income. If you are deemed over-income, you acknowledge that you will be ineligible for RWDP services in accordance with the grant's obligations.
8. Address Change: You acknowledge that the RWDP has a residency requirement for eligibility. If you move outside of the eligible metropolitan areas for RWDP coverage, you must notify RWDP as soon as possible. You acknowledge that you must report any change of address as soon as possible to ensure that you meet the residency requirements for eligibility.
9. Payor of Last Resort: You acknowledge that RWDP is the payor of last resort. You will report to both RWDP and your dental provider all other plans you are enrolled in, such as public plans like Medicaid and Medicare, and/or private dental insurance plans.
    - *If you are a MassHealth member*, you must report this to RWDP in your application. In addition, you must receive care from an RWDP provider that also accepts MassHealth.
    - *If you are a member of a private insurance plan,* you will be held responsible for co-pays and remaining balances from a private plan, as RWDP does not cover these costs. RWDP can only cover treatment that your primary payor has denied.
10. Behavior: You must not engage in hostile behavior, threats, stalking, harassment, assault, and other inappropriate behavior under the standards of Boston Public Health Commission policy towards any program staff, RWDP employees, RWDP dental providers, and other clients served. You acknowledge that RWDP has the right to terminate your program enrollment based on any evidence of engagement of the restrictive behavior standard above.

By initialing Section C on the Cover Page: RWDP Policies, you accept the above declared responsibilities and acknowledge that failure to comply with any of the above listed responsibilities may result in ineligibility for RWDP services or a complete dismissal from RWDP.

RYAN WHITE DENTAL PROGRAM (RWDP) POLICIES ACKNOWLEDGEMENT

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SECTION D: DENTAL PROVIDER/RWDP RIGHT TO REFUSAL POLICY

Participating RWDP dental providers maintain the professional and ethical right to refuse or discontinue services to clients under the following circumstances:

1. *Clinical Determination:* When, in the dental providers' professional judgement, the requested treatment is not clinically appropriate, not considered medically necessary, is outside the providers' scope of practice or inconsistent with accepted standards of dental care.
2. *Non-Complaint or Treatment Refusal:* When a client refuses recommended treatment or fails to follow previously agreed treatment plans.
3. *Behavioral or Safety Concerns:* When a client engages in threatening, abusive, discriminatory or unsafe behavior toward RWDP staff, dental providers and staff or other patients.

RWDP acknowledges that participating dental providers exercise independent professional judgment in the delivery of care. RWDP does not direct, control, or override clinical decisions made by providers, including decisions to refuse, defer, or discontinue dental services in accordance with professional standards and program requirements. In such instances, RWDP will respect the providers determination, and when feasible, assist the client accessing alternative referral locations or points for care.

RWDP does not discriminate based on race, color, national origin, disability, sex, age, religion, sexual orientation, gender identity, or any other protected classification under applicable law.

By initialing Section F on the Cover Page: RWDP Policies, you accept the above declared responsibilities and acknowledge that failure to comply with any of the above listed responsibilities may result in ineligibility for RWDP services or a complete dismissal from RWDP.

CLIENTS – KEEP THIS COPY FOR YOUR RECORDS

SECTION E: CONFIDENTIALITY POLICY

All paper documents, electronic data, and verbal statements made regarding clients' diagnosis, medical and dental history, treatment plans, financial information, and other identifying information are considered confidential information. Clients' information is only accessed electronically or physically, by RWDP staff, when necessary, for the purposes of eligibility, treatment, payment, quality improvement, auditing, or other grant obligations. Electronic and paper documents containing client information are stored securely, either password-protected or physically locked, and archived for the maximum allowable years in accordance with the grants' obligations. All phone calls and verbal communication among RWDP staff, clients, and RWDP dental providers abide by the right to privacy, with the least amount of details conveyed as necessary to achieve the purposes of eligibility, treatment, or payment.

Disclosure of client information to third parties is limited to RWDP dental providers, BPHC Ryan White Services Division, auditors, designated case managers or social workers, health care proxies, or any third party designated by the client as written in the Consent for Release of Information form. In the event of a breach or violation of confidential information, RWDP staff will work promptly to remediate the privacy concerns, resulting in a request for the confidential information to be destroyed immediately or disciplinary action.

By initialing Section D on the Cover Page: RWDP Policies, you accept the above declared responsibilities and acknowledge that failure to comply with any of the above listed responsibilities may result in ineligibility for RWDP services or a complete dismissal from RWDP.

RYAN WHITE DENTAL PROGRAM (RWDP) POLICIES ACKNOWLEDGEMENT

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SECTION F: POLICY ON GRIEVANCE PROCEDURE

Client complaints are given serious consideration. They are managed differently depending on the severity of the complaint.

Client acknowledges that the RWDP establishes the following grievance procedures against either a RWDP-associated dental provider or the RWDP itself.

I. Dental Provider: If a client has a concern about a dental provider to whom RWDP referred them to, the client may call the RWDP at 617-534-2344 for resolution and/or request a new referral.

II. RWDP: Any client may submit complaints against the RWDP must be directed to the RWDP Director by submitting a written description of the issue by regular mail, email to Anthony Silva at ASilva@bphc.org or calling 617-534-2344. All major grievances will be reported within 30 days to the Ryan White Services Team.
If the client's complaint is not resolved or if the client or is not satisfied with the result of the complaint, the client may bring the complaint to the attention of the Director of the Boston Public Health Commission's Infectious Disease Bureau by calling (617)534-5611.

Client acknowledges that any complaints against a non-RWDP dental provider is advised of the following options:

a) Contact the Board of Registration in Dentistry, or
b) Contact a lawyer.

By initialing Section E on the Cover Page: RWDP Policies, you accept that you have been informed of the above policy on the grievance procedure and the appropriate steps to take for serious complaints against RWDP-contracted dental providers or RWDP staff.