

# Ryan White Part B Program Application Instructions



**The Ryan White Part B Program gives help to low income people living with HIV/AIDS in Maine.**

<p><b>Use this application to apply for help paying dental bills within 90 days of service.</b></p>	<p>Dental help is available for people with HIV/AIDS who:</p> <ul style="list-style-type: none"> <li>• live in Maine;</li> <li>• make less than 300% of the federal poverty level (<a href="https://aspe.hhs.gov/poverty-guidelines">https://aspe.hhs.gov/poverty-guidelines</a>);</li> <li>• can't get help anywhere else; AND</li> <li>• have not met an annual cap.</li> </ul>
<p><b>What you need to apply:</b></p>	<ul style="list-style-type: none"> <li>• Complete the 1-page application</li> <li>• Attach a treatment plan from your dentist, a copy of the bill you want paid, and a release form to allow us to talk to your dentist if there are questions about the payment</li> <li>• We cannot pay for more than one dental visit in advance</li> </ul>
<p><b>How you apply:</b></p>	<ul style="list-style-type: none"> <li>• Send your completed application and attachments to:  <b>Maine Ryan White Program</b>  <b>40 State House Station</b>  <b>Augusta, ME 04330</b>  <b>Fax: (207) 287-3498</b></li> </ul>
<p><b>What happens next?</b></p>	<ul style="list-style-type: none"> <li>• Fill out the application completely and clearly. We can't process applications with missing information. (Your Ryan White ID is the same DHS number you use for ADAP.)</li> <li>• Once we receive your complete application, you will get a letter to let you know if payment has been approved or denied.</li> <li>• Please allow up to ten business days for your application to be processed. If you do not hear from us in ten business days, please call us.</li> </ul>
<p><b>Get help with this application</b></p>	<ul style="list-style-type: none"> <li>• Phone: (207) 287-3747. TTY users call Maine Relay 711</li> <li>• Fax: (207) 287-3498</li> <li>• E-mail: <a href="mailto:RyanWhitePartB.DHHS@maine.gov">RyanWhitePartB.DHHS@maine.gov</a></li> </ul>
<p><b>If you need help finding a dentist</b></p>	<ul style="list-style-type: none"> <li>• The community dental clinics as well as the dental clinic at University of New England are familiar with our program requirements and paperwork</li> <li>• Contact your case manager for a recommendation near you</li> </ul>

In accordance with 22 MRS §15, any person who knowingly makes any false written statements or knowingly submits any false documents to receive benefits provided by the Department may face civil penalties by the State of Maine in the Superior Court, which may include, but is not limited to, recovery of those funds disbursed.

## Maine Department of Health and Human Services NONDISCRIMINATION NOTICE

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The Department of Health and Human Services (“DHHS”) does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices. This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 (“ADA”); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination. Questions, concerns, complaints or requests for additional information regarding the ADA and *hiring or employment practices* may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and *programs, services, or activities* may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or [ADA-CivilRights.DHHS@maine.gov](mailto:ADA-CivilRights.DHHS@maine.gov). Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.

# Ryan White Part B Program Dental Assistance Application



Date: \_\_\_\_\_

## 1. Client Information

Name: \_\_\_\_\_ Ryan White ID: DHS \_\_\_\_\_

Has your household income increased in the last six months?  No  Yes, by \$ \_\_\_\_\_ per month

## 2. Request Information

Amount of assistance requested: \$

Dental procedure(s) being performed:

Date of appointment:

**Make check payable to:**

Address for payment:

Patient ID/account number:

## 3. Payer of Last Resort

**Ryan White assistance is only available when no other programs or assistance can help.**

Do you have dental insurance?  Yes  No

Do you have full MaineCare?  Yes  No

**If the Ryan White Program is not paying for the entire cost of services, how will the remainder be paid?**

## 4. Attachments

**\*This application will not be considered complete without required attachments.\***

Please attach:

- A dental treatment plan signed by a licensed dental services provider, AND
- Documentation of the services being provided (must be no more than 90 days old), AND
- The Maine Department of Health and Human Services Authorization to Release Information form filled out with the dentist's information

## 5. Client Agreement

I understand that any refunds for payments made by the Ryan White Part B Program must be returned to the Ryan White Part B Program. All information I shared on this form is true.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Office use only:

Amount used to date: \$

Approved.  Not approved. Reason:

End Date:

FPL:

Date **complete** app received:

Staff initials: