FOR: Managed Care Medi-Cal Patients ONLY
(Ages: 0 up to 6th Birthday)
SF Local Dental Pilot Project Dental Transformation Initiative (DTI)
Care Coordination / Follow-up Request Form

SF Dental Transformation Initiative Local Dental Pilot Project

Patient Label [optional]
Patient name, birthdate, age and gender, if present on the label, do not need to be re-entered on the form.

Submit to the San Francisco CHDP Program within 5 business days of examination – Secure Fax: (415) 581-2327 Phone: (628) 217 - 6889

Patient Name (Last) (First) (Initial)	Language	Date of Service Month Day Year MM / DD/ YYYY

Birthdate Month Day Year MM / DD/ YYYY	Age	Gender Identity (if known) ☐ M ☐ F	Patient's County of Residence	Telephone # ( )	Alternate Phone # ( )

Responsible Person (Name) (Street) (Apt/Space #) (City) (Zip)

Patient Eligibility	County	Aid	Medi-Cal Identification Number

Health Coverage (For Dental Referral Only): ☐ San Francisco Health Plan ☐ Anthem Blue Cross

Ethnic Code ☐
1. American Indian
2. Asian
3. Black
4. Filipino
5. Mex.Amer./ Hispanic
6. White
7. Pacific Islander
8. Other
9. Declined

A. Medical Assessment

Significant Medical History or Special Conditions? (that might impact oral health for ex: Diabetes, Asthma, Mouth drying medications, Autism or Special Needs, etc.)

☐ No ☐ Yes, Specify _____

B. Dental Assessment and Referral Section

☐ Has a Dental Home

☐ No Dental Home/No Dental Visit in last 6 months - Please help connect family to dental clinic.

Referred To: _____

Contact Number: _____

☐ Class I: No Visible Problems	☐ Class II: Visible decay, small carious lesion or gingivitis	☐ Class III: Urgent – pain, abscess, large carious lesions or extensive gingivitis	☐ Class IV: Emergent – acute injury, oral infection or other pain
Mandated annual routine dental *referral (beginning no later than age 1 and recommended every 6 months)* ROUTINE DENTAL REFERRAL	Needs non-urgent dental care	Immediate treatment for urgent dental condition which can progress rapidly	Needs immediate dental treatment within 24 hours PLEASE CALL! (And Fax Form 415.581.2327)

C. Referring Provider Information

Service Location: Office Name, Address, Telephone Number, Fax Number	Provider Name (Print Name)
	Provider Signature
	Date

Care Coordinator: Please fax/mail back information to PCP:
☐ Attended Appt. ☐ Out of County ☐ Declined services ☐ Unable to Contact ☐ Lost to Follow-up ☐ Ineligible for Care Coordination
Exam Date: _____
Comments: _____

DTI (Ages: 0 up to 6th Birthday) Dental Care Coordination/Follow-up Form: Completion Instructions

CHDP Providers:

☐ Submit a copy of the form via Fax (415) 581-2327 to the Local CHDP program for a (0 up to 6th birthday) child with Managed Care Medi-Cal if the child has been referred for the following:
Dental home, Routine Referral or for Dental treatment only

☐ Give a copy of the form to the parent/guardian indicated on the form.

- Keep a copy in patient's medical record.

Explanation of Form Items:

Patient Information (Demographics section):

Patient Name. Enter the patient's last name, first name and middle initial, exactly as it appears on the Benefits Identification Card (BIC), including blank spaces.

Language. Enter the patient's primary language spoken by parents and caregivers at home. Documentation of the language is essential in providing in appropriate and expedited care coordination.

Date of Service. Enter the date the CHDP service was rendered.

Birthdate. Enter the month, day and year of the patient's birth.

Age. Enter the patient's age with one of the following indicators: "y" for years, "m" for months, "w" for weeks, or "d" for days (for example, 5y represents 5 years of age).

Gender Identity If Known. Enter an "F" if the patient is female. Enter an "M" if the patient is male.

Patient's County of Residence. Enter either the name of the county where patient lives (not county where assessment is performed).

Telephone #. Enter the best contact number, including area code where the responsible person can be reached during the day.

Alternate Phone #. Enter alternate number if available.

Responsible Person. Enter the name, street address (including apartment or space number), city, and ZIP code of the parent or legal guardian with whom the patient lives.

Patient Eligibility. Patient eligibility information on the form is completed as follows:

- COUNTY. Enter pts. two-digit county code (obtained when eligibility verification is performed).
- AID. Enter pts. two-digit aid code (obtained when eligibility verification is performed).
- MEDI-CAL IDENTIFICATION NUMBER. Enter pts. ID# from the plastic Benefits Identification Card (BIC) or Immediate Need Eligibility – (Gateway) doc.

Ethnic Code. Enter the appropriate ethnic code (select one only). If the patient's ethnicity is not included in the code list, or if ethnicity unknown, enter code 8 (Other).

A. Medical Assessment:

Significant Medical History or Special Conditions. Enter medical problems or special conditions that might impact oral health including: (Diabetes, Asthma, Allergy medications, motor, developmental, and/or cognitive delay, Special Health Care Needs, or any other condition which may impact oral health).

B. Dental Assessment and Referral Section:

Dental home referral. Enter a check mark (X) in either box for: "Has a Dental Home" or "No Dental Home/No Dental Visit in last 6 months". Note: An annual referral for a routine dental visit must be made even if the patient has no dental problems (Class I) and is 1 year of age or older and has erupted teeth. Be sure to check (X) Class I box.
CA SB75 [P. 32 of Ch.18. SEC. 22.124040.(6)(D)] (Scroll to Ch.18. Page 32)

Referred To and Contact Number. Enter the name & telephone number of the dental provider or agency to which you referred. Enter a check box in one of the Classification boxes: Class I Class II Class III Class IV

Fluoride Varnish Applied. Enter a check mark (X) on the Yes box if the patient had fluoride varnish applied during visit on date of service listed above. Enter a check mark (X) on appropriate box if child did not get fluoride varnish and state reason why not.

C. Referring Provider Information:

Service Location. Enter business name, address, telephone # and fax # w/area code of clinic/office. A provider stamp is acceptable.

Rendering Provider Name. Print legibly or type the provider's name that renders the services.

Provider Signature. Provider or a designated representative must sign.

Date. Enter the date of signature.