PROSPECTIVE PROVIDER FORM

Legal Business Name: _____

Clinic Name/DBA: _____

TIN: _____Org/Billing NPI:_____

Owner/Provider: _____

Primary Office Contact: _____

Office Address: _____

Mailing Address (if different than physical address): _____

City: _____ State: _____ Zip Code+4: _____

Office Phone: _____ Office Fax: _____

E-mail: _____ Web Address: _____

Type (circle one): General Dentist Pedo Perio Endo Oral Surgeon Denturist EPDH
Organization Type: Sole Proprietorship Partnership LLC PC Other: _____

For additional clinic providers, submit a list with provider full names, degree, NPI, and Medicaid enrollment number.

OFFICE HOURS:

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Community Outreach such as delivering services in alternate setting such as schools, Head Start programs, Nursing Homes etc. requires Capitol Dental Care approval of these activities as a condition of payment consideration. Are you requesting to participate in community outreach from this location?
Yes ____ No ____ **If yes**, please explain: _____

Will you be providing dental treatment in your office using **general anesthesia or I.V. or conscious sedation**?
Yes ___ No ____ **If yes**, have you notified the Oregon Board of Dentistry? Yes____ No ____
Will you be administering the sedation? Yes____ No ____ **If no**, please indicate provider administering sedation:
_____
_____

Is your office accepting **new patients**? Yes_____ No _____ **If no**, please identify any limitations:
_____

Do you have patient **age limitations**? Yes_____ No _____ **If yes**, please indicate age: _____
Will you see **special needs** patients? Yes_____ No _____ **If yes**, please identify any limitations:
_____

Is your office accessible by **Public Transportation** Yes____ No ____

Due to new federal regulations, we are required to include information in our directory regarding every office. Please complete the following information.

Language & Communication Access:
Do you speak a language other than English? Yes ____ No ____ Language(s):_____
Does your clinic staff speak a language other than English? Yes ____ No _____
If yes, please list language(s): _____

Do you offer Interpreter services? Yes ____ No ____

Cultural Competency Training: Have you and your staff completed?
Yes ____ No ____ **If yes**, please list year completed: _____

Please indicate **Yes**, **No** or **N/A** on the ADA access aids you have in your location:
**Not Applicable means the element is either not present at the facility so does not apply or the facility has received an exemption.*

Exterior Building Accessibility – Indicate ADA Compliance with:
_____ Accessible parking spaces _____ Access aisles/van accessible
_____ Curb ramps _____ Surfaces/Walkways _____ Wheelchair Ramps
_____ Door width _____ Door Handles/thresholds _____ Protruding Objects

Interior Building Accessibility - Indicate ADA Compliance with:
_____ Door Width _____ Aisle width, reach & turning space _____ Table placement/height
_____ Ramps _____ Elevators _____ Water Fountains _____ ATM's
_____ Accessible medical equipment, exam rooms & maneuvering space

Restrooms - Stalls & single-occupant restrooms. Indicate ADA Compliance with:
_____ Entrance, turning space, mirrors and sinks, Pipes, floor space, faucets and dispensers, Toilets and grab bars.
_____ 5 feet wheelchair turning diameter

Equipment *for participants with mobility limitations*:
Exam and procedural tables/chairs that:
_____ Are height adjustable with a minimum of 17-19" from the floor to the top of the cushion.
_____ Have cushion tops 24" or greater to accommodate larger participants.
_____ Have higher weight capacity, 400lbs or greater to accommodate larger participants.
_____ Have adjustable handrails and/or side rails.
_____ Have foot/leg supports than can be adjusted and locked.
_____ Positioning aids are available and used as needed.

Weight Scales with:
_____ Sturdy handrails
_____ Higher weight capacity (400-800lbs+)
_____ Large and easy to read display (digital)
_____ Scale platforms accommodate large power wheelchairs.
_____ Instructions next to or attached on how to weight a person using a mobility aid.

Lift Equipment and/or Lift Assistance:
_____ Provider provide participants transfer assistance on and off of equipment (this includes use of lift equipment when needed) by trained staff.
_____ Lift equipment is available to assist staff with transfers (portable, overhead or ceiling mounted).

Completed By: _____ Date: _____