Santé et Services sociaux Québec

DT9463

File number

Resident's last name

Resident's first name

Date of birth — Year / Month / Day — Sex: ☐ M ☐ F

Health insurance number — Expiry: Year / Month

Area code / Phone number — Area code / Phone number (alt.)

ORAL HEALTH CARE IN RESIDENTIAL AND LONG-TERM CARE CENTRE (CHSLD)

Treatment Plan and Cost Assessment
Dentist
Denturist

ORAL HEALTH CARE OR REMOVABLE DENTURE SERVICES (MAKING OR REPAIRING)

Suggested Treatment Plan	Alternative Treatment Plan
Prognosis	**Prognosis**

COST ASSESSMENT *(Use the calculation table on reverse side)*

Suggested Treatment Plan ☐ Accepted			Alternative Treatment Plan ☐ Accepted		
Total cost	Amount paid by the residentt	Amount paid by the establishment (A – B)	Total cost	Amount paid by the resident	Amount paid by the establishment (C – D)
A $	**B** $	$	**C** $	**D** $	$

CONSENT

I, the undersigned, consent to the treatment plan that I accepted to be carried out as is described above. I also recognize that the dentist or denturist explained the treatments and potential complications to me and that they answered my questions to my satisfaction.

Signature of the resident or legal representative	Signature of the witness	Date (Year / Month / Day)

☐ Dentist ☐ Denturist			Date (Year / Month / Day)
Last name and first name	Permit number	Signature	

☐ Resident's file
☐ SAPA program management

Resident's first and last name	File number

COST CALCULATION TABLE ***(To be filled out by the dentist or denturist)***

	Suggested Treatment Plan		Alternative Treatment Plan	
	Procedure (Code)	Cost	Procedure (Code)	Cost
1		$		$
2		$		$
3		$		$
4		$		$
5		$		$
6		$		$
7		$		$
8		$		$
9		$		$
10		$		$
	Total Cost A	$	**Total Cost C**	$

Write only the costs related to the exam, curative care and services for making or repairing removable dentures (preventative care is offered at no cost).

CALCULATION OF AMOUNT OF COSTS PAID BY THE RESIDENT ***(To be filled out by the establishment)***

Suggested Treatment Plan				Alternative Treatment Plan			
Total Cost		Percent paid by the resident *(10% to 100%)*	Amount paid by the resident *(A x appl. %)*	Total Cost		Percent paid by the resident *(10% to 100%)*	Amount paid by the resident *(A x appl. %)*
A	$	%	**B** $	**C**	$	%	**D** $

The amount of the cost paid by the resident is calculated based on the terms set out in the circular on the goods and services not covered by the contribution of accommodated adults, personal expenses allocations and the regulations relative to special needs.