DONATED DENTAL SERVICES (DDS) APPLICATION

S.D. Donated Dental Services
PO Box 7018
Pierre, SD 57501
FAX: 605-224-9168
Email: amy@sddental.org

APPLICANT INFORMATION

Name: _____ Phone: (___) _____(home)

Address:_____ Phone: (___) _____(cell)

City:_____ Zip Code:_____ County:_____

Email Address:_____

Date of Birth:_____ Age:_____ Male: □ Female: □

Marital Status: Single □ Married □ Divorced □ Widowed □

Are you a veteran? Yes □ No □

Contact Person Name (relative, friend, etc.):_____

Phone: ( ) _____ Relationship to You:_____

SECTION 1

ELIGIBILITY OVERVIEW

1. Do you have a permanent disability? Yes □ No □
2. Are you age 65 or older? Yes □ No □
3. Do you need dental care which is required by a physician due to a medical necessity? Yes □ No □
   (If "yes", please have your physician fill out the attached "Medical Necessity Triage Form")

   If you answered "NO" to all of the above, you do not qualify for our program.
4. Do you receive the following benefits? Medicare □ Medicaid □
   If you have Medicaid, does it include dental benefits? Yes □ No □
5. Do you have dental insurance? Yes □ No □ Name of Insurance_____

   If you answered "YES" to 4 and/or 5, you are required to use your benefits to have all covered services taken care of or prove that you were unable to access the care you need before you will be considered for the program.
6. Are you eligible to receive dental benefits through the Veterans Affairs (VA)? Yes □ No □
7. Are you eligible to receive dental benefits through the Indian Health Service (IHS) or other Tribal Clinics? Yes □ No □
8. Is your household income greater than the 185% of the Federal poverty level? (See chart) Yes □ No □
9. Have you received treatment through the DDS program before? Yes □ No □
10. Do you have the financial means to afford dental care (i.e., savings, investments, equity in your home)? Yes □ No □

If you answered "YES" to 6, 7, 8, 9, or 10, you are not eligible for this program.

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SECTION 2

HOUSEHOLD FINANCIAL INFORMATION

Monthly Income:

Are you able to work outside the home? Yes □ No □

If you are employed, place of employment:_____

Your monthly income: $_____ Number of hours worked per week:_____

Number of people living in your household: _____

Name other persons in the household	Age	Relationship to you	Monthly Income
			$
			$
			$
			$
			$

Household Financial Assistance

(please include monthly benefits for everyone in your household who receives any of the below benefits):

Program	Amount
Social Security Disability (SSDI) Enclose a copy of SSDI income statement(s)	$
Supplemental Security Income (SSI) Enclose a copy of SSI income statement(s)	$
Social Security (62 years or older) Enclose a copy of SS income statement(s)	$
Temporary Assistance to Needy Families (TANF) Enclose a copy of TANF income statement(s)	$
Other	$
Total Monthly Income from Assistance:	$

Total value of savings: $_____ Total value of investments/assets: $_____

SNAP (food stamps) Benefits? Yes □ No □ Monthly Amount: $_____

Monthly Expenses

Housing: $_____ Own: □ Rent: □ Phone: $_____

Utilities: $_____ Cable/Internet: $_____

Food: $_____

Medications/Medical Costs: $_____ Out-of-Pocket Health Insurance: $_____

Credit card/Loan payments: $_____ Life/Health Insurance: $_____

Is there a car(s) in the household? Yes □ No □ If so, how many that run? _____

If yes, make(s): _____ Model(s): _____ Year(s):_____

Car payment(s): $_____ Car insurance/Car expenses/Gas: $_____

Other monthly expenses: $_____

Total monthly household expenses: $_____

SECTION 3

MEDICAL INFORMATION

Major disabilities and/or health problems (explain in as much detail as possible. Do not include dental problems as part of this question):

Primary Physician's Name: _____

Phone: (____) _____ Fax: (____) _____

Psychiatrist's Name and phone number (if you have a mental disorder) _____

Do you use a: wheelchair □ cane □ walker □ scooter □?

If you only qualify due to a medical necessity (not over age 65, or permanently disabled), you MUST fill out a "Medical Triage Form" and have a doctor's referral).

SECTION 4

DENTAL INFORMATION

Briefly describe your dental needs:

How many natural teeth do you have remaining? # Upper _____ # Lower _____

Name of Last Dentist: _____

Approximate date of last dental visit: _____

How will you get to your dental appointments? _____

Please list other cities or how far you are willing to travel to get dental treatment:

Are any family members able to contribute to costs of your dental treatment? Yes □ No □

If yes, please explain: _____

Are any other sources available to help pay for dental care (churches, other agencies)? Yes □ No □

If yes, please explain: _____

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SECTION 5

REFERRING AGENCY OR AGENCY YOU RECEIVE SERVICES THROUGH

Agency Name: _____

Name of Caseworker: _____ Phone: _____

Mailing Address: _____

Email Address: _____

ADDITIONAL INFORMATION:

AGREEMENT

Please read the following statements.
If you understand and agree to the conditions, please sign, and date at the bottom of the form.

1. Agreement – Release of Information

A. I understand that I will need to provide personal information that includes but is not limited to, medical, dental, and financial condition. I authorize the DDS Program to obtain information from, and share information, with my physician(s), dentist(s), contact people I listed, and/or government or private agencies in order to determine my eligibility for the DDS Program.

B. I understand information provided by me or others as noted above may be given only to the volunteers involved in my treatment and will be held confidential. I authorize the DDS Program to share information with and obtain information me with one of more dentist(s) volunteering in the DDS Program.

C. I understand if my disability is AIDS or HIV-related, I authorize the DDS Program to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS Program and hold the DDS Program harmless in doing so. I also understand that I have a right to revoke consent at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it. Furthermore, this consent will expire by _____or upon _____.

2. Eligibility & Treatment Understanding

A. I realize that my application to the DDS Program does not assure I will be referred for an examination. I understand that the DDS Program will determine whether I am eligible for the program and, if so, will try to refer me to a participating volunteer dentist. I further understand that the dentist, not the organization, is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

B. I understand that the dentist(s) has volunteered to treat my existing dental condition only and is not obligated to provide donated care in the future or to maintain me as a patient.

C. I understand that a volunteer dentist in the DDS program may discontinue providing services to me at any time upon reasonable notice provided to me. I understand that, after receiving such notice, I am responsible for obtaining the services of an alternate dentist. I also understand that the Donated Dental Services Program has no responsibility to assist me in obtaining the services of an alternate dentist.

3. My Responsibilities

I understand the importance of keeping all scheduled appointments and agree to make them.

To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current physical, medical, and financial status.

Signature of client: _____ Date: _____

Signature of client's guardian (if necessary) _____ Date: _____

4. Optional Photo and Information Consent Form

I authorize the Donated Dental Services Program to use my name, information, statements, or photograph for public relations purposes, and to attribute my statements to me as an expression of my personal experience. I understand that this information may be used in dental journals, website(s), media articles, advertisements or other marketing materials that promote the DDS Program and encourage involvement from dental professionals and funders. I also agree that no material needs to be submitted to me for any further approval, and I give the DDS Program the right to copyright such material if necessary. I understand that if I don't grant permission, it will not affect my eligibility for receiving services through the DDS Program.

Signature of client: _____ Date: _____

Signature of client's guardian (if necessary) _____ Date: _____

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Medical Necessity Triage Form

(If you cannot receive essential medical treatment due to your current dental condition,
this form must be completed by your medical doctor)

Patient Full Name: _____ Date: _____

Printed Name of Physician: _____

Physician Signature: _____Physician Phone: _____

Medical Necessity of Dental Care:

Given medical circumstance(s), are you concerned the person's dental condition poses a significant risk of increased morbidity?

_____ Yes* _____ No (if no, do NOT proceed with form)

**If yes, please grade risk:*

_____ Moderate (needs care within 6-12 mths)

_____ Severe (needs care within 3-6 mths)

_____ Urgent (present status an unacceptable risk to overall care)

Medical Condition(s):

Organ Transplantation: Organ_____ Candidate_____ Recipient _____

Renal Function: Compromised _____ On hemodialysis _____ Planned hemodialysis _____

Diabetes: Type 1 _____ Type 2 _____ (please explain_____)

Cancer: Type: _____ Active _____ Remission _____

Chemotherapy Planned _____ Active _____

Radiation Planned_____ Active _____

Immunodeficiency: Immunosuppression disease or medication (specify _____)

Cardiovascular: Heart Valve _____ Stent _____ Other _____

Orthopedic Hardware: (please explain) _____

Intubation Risk: (please explain) _____

Bisphosphonate therapy: _____

Other: (please explain) _____

South Dakota Donated Dental Services Program:
Please complete and fax to 605-224-9168 or email to amy@sddental.org