



Maryland Foundation of Dentistry for the Handicapped
an affiliate of the National Foundation of Dentistry for the Handicapped

6410 Dobbin Road, Suite F
Columbia, Maryland 21045-4744

410/964-1944
410/964-9978 Fax
877-DDS-PRGM

Murray D. Sykes
President

Gary Colangelo
Vice President

Sheldon Silverman
Secretary

Anthony A. Cuzzo, Jr.
Treasurer

Directors
Samuel Blum
Roosevelt Bush
Arnold S. Feldman
Arthur Fridley
Larry Greenbaum
Spencer Hornstein
Edward W. Kordoski
John E. Patterson
Susan Pearson
William H. Schneider
Mary Ziomek

Hello:

In response to your recent inquiry about the availability of free dental care, we are pleased to provide the following information about the Donated Dental Services Program.

ELIGIBILITY: Dentists throughout the state have volunteered to provide comprehensive dental care at no charge to people of all ages, who, because of a serious disability of impaired mental and/or physical health, lack adequate income to pay for needed dental care. All patients admitted into the program must have transportation to the dental office and must keep all appointments. The Donated Dental Services Program is unable to provide sedation services for simple procedures, such as x-rays and cleanings.

COST: Dental services are provided free of charge to eligible individuals.

APPLICATION PROCEDURES:

Step One: Please complete, sign, and return the enclosed application.

Step Two: When your application has come up for review, a patient-care coordinator will call to obtain additional information. Please do not call to check on the status of your application. These phone calls take up much of our time and only delay treatment time for all of our clients. A coordinator will call you when your application is up for review.

Step Three: The patient-care coordinator will send a referral with the patient's information to a volunteer dentist.

Step Four: You will be contacted by a dentist's office to schedule an appointment. It is very important that you do not miss any appointments or arrive late. Failure to keep appointments and be on time will result in termination from program.

Upon receipt, your application will be placed on our waiting list. Please be patient. Due to program limitations, we now have a 18-24 month waiting list in some counties. Therefore we are unable to provide emergency care. The patient-care coordinator will contact you when your application has come up for review.

Sincerely,

Lilian Marsh
DDS Program Director

Nancy Messick-Evans
DDS Patient-Care Coordinators
Revised: 2-10-06

Barbara Law
DDS Patient Care Coordinator

Maryland Foundation of Dentistry for the Handicapped – Application for Services

6410 Dobbin Road, Suite F
Columbia, Maryland 21045
Phone: 410-964-1944

Fax: 410-964-9978
1-877-337-7746
mfdhall@mfdh.org

REFERRING AGENCY -IF APPLICABLE

Agency Name: _____

Phone: (____) _____ Name of Caseworker: _____

Address: _____

City, State, & Zip: _____

APPLICANT

Name: _____ Social Security #: _____

Address: _____

City, State, & Zip: _____ County: _____

Telephone #: (____) _____ Number of individuals in household: _____

Date of Birth of Applicant: _____ Means of Transportation: _____

MAJOR DISABILITIES OR HEALTH PROBLEMS:

List of Current Medications:

Please check box if you have had any problems with the following:

- Heart Kidneys Liver Allergies to Medications

Please provide explanation if you checked the any of the above boxes:

Please list all major surgeries and dates:

Is the applicant able to work: yes no If yes, please list current employer and job responsibilities:

Does the applicant require wheelchair access: yes no

Primary Physician's Name: _____ Phone #: (____) _____

Specialist Physician's Name: _____ Phone #: (____) _____

DENTAL NEEDS

Briefly describe applicant's dental needs:

Name of last dentist: _____ Phone #: (____) _____

Date of last dental visit: _____ Service performed: _____

FINANCIAL INFORMATION

Is the applicant employed? yes no Monthly wages: \$ _____

Is spouse employed? yes no Monthly wages: \$ _____

Income from Public Assistance: \$ _____

Income from: SSI SSDI PENSION OTHER (circle all that apply) \$ _____

Total Monthly Household Income: \$ _____

Does the applicant receive food stamps? yes no Amount: \$ _____

Total Value of Savings/Investments: \$ _____

Does the applicant receive Medical Assistance Benefits? yes no

Please list your medical insurance provider, your policy number, and their customer service number (located on the back of your insurance card) :

Does the applicant have any dental insurance? yes no

If yes, please explain dental coverage: _____

MONTHLY EXPENSES

Housing	\$ _____	Phone	\$ _____	Food	\$ _____
Utilities	\$ _____	Water	\$ _____	Car Insurance	\$ _____
Car Payment	\$ _____	Gas/Car Expense	\$ _____	Health Insurance	\$ _____
Medications:	\$ _____	Other \$:	_____		

Total Monthly Household Expenses: \$ _____

Does the applicant own a car? yes no Make, model, and year of car: _____

Are family members able to contribute to applicant's dental costs? yes no

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

I understand that I will need to provide personal information that includes, but is not limited to medical, dental, and financial conditions.

I give my consent for the coordinator to obtain information relevant to my eligibility for the DDS Program from my physician, dentist, individuals who know me and/or government or private agencies.

I give permission to the coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the DDS Program.

I realize that application to the DDS Program does not ensure I will be referred for an examination or that I will be accepted as a patient following an examination.

I understand that the Maryland Foundation of Dentistry for the Handicapped, which coordinates the Donated Dental Services Program, will determine whether I am eligible for the program and, if so, will seek to refer me to a participating volunteer dentist. I further understand that the dentist, not the Foundation, is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

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

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hours notice to the dentist, can and will disqualify me from obtaining further dental treatment through the program.

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

Signature of Client: _____

Date: _____

Signature of Guardian: _____

Date: _____