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## RHODE ISLAND DONATED DENTAL SERVICES (DDS)

In response to your recent inquiry about the availability of free or low-cost dental care, we are pleased to provide the following information about the Donated Dental Services (DDS) program.

**ELIGIBILITY:** Dentists throughout Rhode Island have volunteered to provide comprehensive dental care at no charge to people of all ages who, because of a serious disability, advanced age, or medical problems, lack adequate income to pay for needed dental care. There are no rigid financial eligibility requirements.

**COST:** There is generally no cost to qualifying individuals; however, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is involved.

### APPLICATION PROCEDURES:

- Step One please complete, sign, and return the enclosed application,
- Step Two when your application comes up for review, a referral coordinator will call to obtain additional information (those who don't qualify will be told so during the call),
- Step Three the referral coordinator will share the information about a person tentatively accepted with a volunteer dentist,
- Step Four you will be notified of the dentist's name and phone number and you will be responsible for scheduling an appointment for an examination. Final acceptance into the program will only be made after the clinical examination when the specific treatment needs are established.

Upon receipt, your application will be placed on our waiting list. Please be patient; due to program limitations, we are not able to process each application as soon as it is received. The referral coordinator will contact you when your application comes up for review.

We are sorry you are experiencing a dental problem and we hope the Donated Dental Services (DDS) program may be a source of some help.

Sincerely,

Michelle Palmer  
 DDS Program Coordinator

**APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM**

RHODE ISLAND DONATED DENTAL SERVICES  
1800 15<sup>TH</sup> STREET, SUITE 100  
DENVER, CO 80202  
1-866-572-9390 TOLL FREE

HAVE YOU RECEIVED SERVICES  
THROUGH THE DDS PROGRAM BEFORE:  
YES \_\_\_\_ NO \_\_\_\_

**APPLICANT**

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NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PLEASE CIRCLE: MALE FEMALE

CITY, STATE, ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_\_ MARRIED \_\_\_\_ DIVORCED \_\_\_\_ WIDOWED \_\_\_\_

HOW DID YOU HEAR ABOUT THE DDS PROGRAM? \_\_\_\_\_

CONTACT PERSON (RELATIVE, FRIEND, ETC.):

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP TO YOU: \_\_\_\_\_

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: \_\_\_\_\_

<u>NAME OF EACH PERSON</u>	<u>AGE</u>	<u>RELATIONSHIP TO YOU</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAJOR DISABILITIES OR HEALTH PROBLEMS (EXPLAIN IN AS MUCH DETAIL AS POSSIBLE):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES \_\_\_\_ NO \_\_\_\_

IF YES, PLEASE LIST THE MEDICATIONS: \_\_\_\_\_

DO YOU REQUIRE WHEELCHAIR ACCESS? YES \_\_\_\_ NO \_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHYSICIAN'S PHONE #: \_\_\_\_\_

**FINANCIAL INFORMATION**

**MONTHLY INCOME:**

ARE YOU ABLE TO WORK? PART-TIME: YES \_\_\_\_\_ NO \_\_\_\_\_ FULL TIME: YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, HOW MANY HOURS PER WEEK CAN YOU WORK: \_\_\_\_\_

IF NO, PLEASE EXPLAIN: \_\_\_\_\_

PLEASE LIST THE DATE WHEN YOU WERE MOST RECENTLY EMPLOYED: \_\_\_\_\_

ARE YOU EMPLOYED CURRENTLY? YES \_\_\_ NO \_\_\_ PLACE OF EMPLOYMENT: \_\_\_\_\_

YOUR MONTHLY WAGES: \$ \_\_\_\_\_

IS YOUR SPOUSE EMPLOYED? YES \_\_\_ NO \_\_\_ PLACE OF EMPLOYMENT: \_\_\_\_\_

SPOUSE'S MONTHLY WAGES: \$ \_\_\_\_\_

IF SPOUSE IS UNEMPLOYED, WHY? \_\_\_\_\_

**PUBLIC ASSISTANCE (PLEASE ATTACH A COPY OF ALL INCOME SOURCES):**

PROGRAM                      MONTHLY AMOUNT                      HOW LONG HAVE YOU RECEIVED BENEFITS?

SSI: \_\_\_\_\_

SOCIAL SECURITY DISABILITY: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

AFDC: \_\_\_\_\_

UNEMPLOYMENT: \_\_\_\_\_

OTHER: \_\_\_\_\_

OTHER: \_\_\_\_\_

TOTAL MONTHLY INCOME OF ALL MEMBERS OF HOUSEHOLD: \$ \_\_\_\_\_

TOTAL VALUE OF SAVINGS: \_\_\_\_\_

TOTAL VALUE OF INVESTMENTS: \_\_\_\_\_

TYPE OF INVESTMENTS: CDs \_\_\_\_\_ IRAs \_\_\_\_\_ ANNUITIES \_\_\_\_\_ OTHER \_\_\_\_\_

FOOD STAMPS? YES \_\_\_ NO \_\_\_ MONTHLY AMOUNT: \$ \_\_\_\_\_

**MONTHLY EXPENSES:**

RENT: \$ \_\_\_\_\_ MORTGAGE: \$ \_\_\_\_\_ PHONE: \$ \_\_\_\_\_ FOOD (NOT INCL. FOOD STAMPS): \$ \_\_\_\_\_

GAS/ELECTRICITY: \$ \_\_\_\_\_ WATER/SEWER: \$ \_\_\_\_\_ CAR PAYMENT: \$ \_\_\_\_\_

CAR INSURANCE: \$ \_\_\_\_\_ GAS/CAR EXP: \$ \_\_\_\_\_ HEALTH INSURANCE: \$ \_\_\_\_\_

LIFE/BURIAL INS.: \$ \_\_\_\_\_ MEDICATIONS: \$ \_\_\_\_\_ MEDICAL COSTS: \$ \_\_\_\_\_

OTHER: \_\_\_\_\_

OTHER: \_\_\_\_\_

TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ \_\_\_\_\_



**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 condition.

I give my consent for the referral 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 for the referral coordinator to share pertinent information, about my eligibility, with one or more volunteer dentist in the DDS program. If my disability is AIDS or HIV related, I give the Foundation of Dentistry for the Handicapped (FDH) permission to release information about my medical condition and hold FDH harmless for doing so.

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

I understand that the Foundation of Dentistry for the Handicapped, which coordinates the DDS 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 only and are not obligated to provide donated care in the future or to maintain me as a patient.

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

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

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of person referring (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE CHECK OFF ALL LOCATIONS OF DENTAL OFFICES THAT YOU CAN GET TRANSPORTATION TO:

HARRISVILLE	___	JOHNSTON	___	RUMFORD	___
NORTH SMITHFIELD	___	CRANSTON	___	EAST PROVIDENCE	___
WOONSOCKET	___	WARWICK	___	RIVERSIDE	___
LINCOLN	___	EAST GREENWICH	___	WARREN	___
CUMBERLAND	___	NORTH KINGSTOWN	___	PORTSMOUTH	___
PAWTUCKET	___	WICKFORD	___	MIDDLETOWN	___
NORTH PROVIDENCE	___	NARRAGANSETT	___		
PROVIDENCE	___	WAKEFIELD	___ NEWPORT		
SCITUATE	___	CHARLESTOWN	___		
		WESTERLY	___		

**Optional Photo and Information Consent Form**

"I give permission to the Foundation of Dentistry for the Handicapped 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 programs of the Foundation 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 Foundation the right to copyright such material if necessary. **I understand that if I don't grant this permission, it will *not* affect my eligibility for receiving services through Donated Dental Services (DDS).**"

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

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