



A PROGRAM OF THE
NATIONAL FOUNDATION OF DENTISTRY
FOR THE HANDICAPPED

A charitable affiliate of the
American Dental Association

c/o Seattle-King County Dental Society
2201 Sixth Avenue, Suite 1210
Seattle, WA 98121-1857
206/441-8777
Fax: 206/443-9308

Hello: _____

In response to your recent inquiry about the availability of donated dental care, we have enclosed an application. ***Please keep this page*** as it covers the requirements, application procedures and other important details about our program.

Dentists in the Seattle area have volunteered to provide comprehensive dental care at no charge to **King County residents** who are unable to pay for needed dental care due to a disability, serious medical problem, advanced age or lack of income. Applicants may go through the program ***one time only*** and must have *extensive dental needs* that cannot be resolved through other available programs or resources.

Please note: Donated Dental Services depends on the goodwill and availability of volunteer dentists and labs. Donating dentists determine the diagnosis and make decisions on necessary treatment. Due to the high number of applicants, it may take 12 months or more to receive assistance. *Those who need immediate care should call the Seattle King County Dental Society at 206-443-7607 for a list of low-cost dental clinics or get the list online at SKCDS.org.*

THE APPLICATION PROCESS

Step One: Please fill out the application as completely as possible, including financial income and expenses so that a preliminary determination of eligibility can be made. Remember to **sign and date** the application.

Step Two: Upon receipt, your application will be placed on our waiting list. *Please be patient.* When a dentist is available in your area, the referral coordinator will call to obtain additional information and make a final determination of eligibility.

Step Three: Your information will be shared with the available dentist and you will be contacted if the dentist agrees to see you for an initial examination. **Final acceptance** into the program will only be made after the clinical examination, after the specific treatment needs are established.

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,

Deb Blake
DDS Program Coordinator

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

DONATED DENTAL SERVICES
C/O SEATTLE-KING COUNTY DENTAL SOCIETY
2201 SIXTH AVENUE SUITE 1210
SEATTLE, WA 98121
PHONE: (206) 441-8777 FAX: (206) 443-9308

DATE OF APPLICATION: _____
HAVE YOU RECEIVED SERVICES THROUGH
DDS PROGRAM BEFORE? ___ YES ___ NO

APPLICANT

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: _____

NAME OF EACH PERSON	AGE	RELATIONSHIP TO YOU
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

DO YOU REQUIRE WHEELCHAIR ACCESS? ___ YES ___ NO

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____

FINANCIAL INFORMATION

MONTHLY INCOME:

ARE YOU ABLE TO WORK? ____ YES ____ NO

IF NO, PLEASE EXPLAIN: _____

ARE YOU EMPLOYED? ____ 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:

PROGRAM	MONTHLY AMOUNT	HOW LONG HAVE YOU RECEIVED BENEFITS?
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SSI: _____

SOCIAL SECURITY DISABILITY: _____

TANF: _____

SOCIAL SECURITY: _____

UNEMPLOYMENT: _____

OTHER: _____

OTHER: _____

TOTAL MONTHLY HOUSEHOLD INCOME: \$ _____

TOTAL VALUE OF SAVINGS: _____

TOTAL VALUE OF INVESTMENTS: _____

TYPE OF INVESTMENTS: _____

FOOD STAMPS? ____ YES ____ NO MONTHLY AMOUNT: \$ _____

MONTHLY EXPENSES:

HOUSING: \$ _____ 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: _____

OTHER: _____

TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ _____

DENTAL NEEDS _____

BRIEFLY DESCRIBE YOUR DENTAL NEEDS: _____

NAME OF LAST DENTIST: _____ PHONE#: _____

DATE OF LAST DENTAL VISIT: _____

HOW WILL YOU GET TO DENTAL APPOINTMENTS? _____

PLEASE LIST OTHER TOWNS YOU CAN GET TO: _____, _____,

DO YOU RECEIVE MEDICAID BENEFITS? ____ YES ____ NO MEDICAID # _____

DO YOU HAVE DENTAL INSURANCE? ____ YES ____ NO

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 (i.e. churches, service organizations, other agencies, etc.)? ____ yes ____ no

If yes, please explain: _____

Do you own a car? ____ yes ____ no

Make, model, and year of car: _____

REFERRING AGENCY

AGENCY NAME: _____ PHONE: _____

NAME OF CASEWORKER: _____

ADDRESS: _____

CITY, STATE ZIP: _____

ADDITIONAL INFORMATION

Use this space to elaborate on any information not sufficiently explained in other areas.

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 (if necessary): _____ Date: _____

Signature of person referring (if applicable): _____ Date: _____

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: _____