



Dear Applicant:

Thank you for contacting the Donated Dental Services (DDS) program for an application for services. The DDS program is a network of volunteer dentists, specialists, and laboratories that understand there are few resources available to help elderly and disabled people receive dental care. Over 500 dentists and over 130 laboratories across the state have registered with the program. Since the program began in 1997, these volunteers have helped hundreds of elderly and disabled people receive free dental care.

The DDS program is not equipped to handle emergency cases.

To be eligible for services through the DDS program, applicants must meet the following requirements:

- **Elderly**
(over age 62)

or

- **Permanently disabled**
(receiving SSI, SSDI, etc.)

In addition the applicant must:

- **Demonstrate sufficient financial need**
(household income must be within 150% of federal poverty guidelines).
- **Have reliable transportation**
- **Require comprehensive dental care**
(more than simply a check-up, cleaning, and a few fillings.)

After you submit your application, you will be notified within **30** days of the receipt of your application whether you have passed the first phase of the eligibility process. Once your application has passed the first round of our eligibility process, you will be added to the existing waiting list. **Please be prepared to wait for services.** Due to the high demand for dental care, over 900 people in Virginia are waiting to be seen by a volunteer dentist. The DDS program will contact you by letter when a volunteer dentist is available from within your community, so you must notify us if you have an address or telephone number change. **Your application will be valid for two years.** If—after two years—you have not been contacted, please submit another application. Do not call the DDS program office to inquire about the status of the waiting list in your community, as we are unable to determine the wait for services.

Please fill out the entire application to the best of your ability and return it to the address given on the top of the application. DDS treats patients in a **first come first serve manner**, as readily as possible. If you have any questions about how to fill out the application, please feel free to contact me at (804) 264-9010.

Sincerely,

Shannon Jacobs

Shannon Jacobs
DDS Program Coordinator



7525 Staples Mill Road
Richmond, VA 23228
(804) 264-9010 Phone
(804) 261-1660 FAX

APPLICANT INFORMATION

Name: _____ Phone: _____

Address: _____

City, State ZIP _____

Date of Birth: ___/___/___ Age: _____ County: _____

Please Circle: Male Female

Marital Status: Single Married Divorced Widowed Separated

Contact Person (relative, friend, etc):

Name: _____ Phone: _____

Relationship to you: _____

Number of people in your household: _____

Name of each person	Age	Relationship to you
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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# _____

For office use only

Date Received ___/___/___

CS ___/___/___

Status _____

NLS ___/___/___

Area _____

Intake ___/___/___

FINANCIAL INFORMATION

Monthly Income: *****Please list incomes for every member of household*****

Are you able to work? Part-Time ___ Yes ___ No Full-Time ___ 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 your spouse is unemployed, why? _____

PUBLIC ASSISTANCE:

<u>Program</u>	<u>Monthly Amount</u>	<u>When did you begin receiving this?</u>
SSI:	_____	_____
Social Security Disability:	_____	_____
AFDC:	_____	_____
Social Security:	_____	_____
Unemployment:	_____	_____
Other:	_____	_____
Food Stamps	_____	_____

Other household member's Income

<u>Name</u>	<u>Monthly Income</u>	<u>Name</u>	<u>Monthly Income</u>
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____

Total value of savings: \$ _____ Total value of investments \$ _____

MONTHLY EXPENSES:

Housing: \$ _____ Phone \$ _____ Food (not including food stamps) \$ _____
 Gas/Electric \$ _____ Water/Sewer \$ _____ Car Payments: \$ _____ Car Insurance _____
 Gas/Car Exp: \$ _____ Health Ins \$ _____ Life/Burial Ins. \$ _____ Medications \$ _____
 Other medical costs \$ _____ Other: _____

TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ _____

TRANSPORTATION

How will you get to dental appointments? _____

Please list other towns you can easily get to: _____, _____, _____

Do you own a car? Yes No If yes, list Make, Model and year: _____

INSURANCE

Do you receive Medicaid benefits? Yes No If yes, list you member # _____

Do you have dental insurance? Yes No If yes, through what company? _____

Have you ever been through the Donated Dental Services Program before? 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: _____

Are you able to make payments toward your dental treatment? Yes No If yes, how much \$ _____

REFERRING AGENCY

Agency Name: _____ Phone #: _____

Name of case manager or social worker: _____

Address: _____

E-mail _____ Fax#: _____

Should we contact your case manager/ social worker in regards to your application? Yes No

ADDITIONAL INFORMATION

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

HEALTH HISTORY QUESTIONNAIRE

All the information that you provide may be shared with your prospective volunteer dentist.

This information is current as of ____/____/____

PATIENT INFORMATION

Patient Name: _____ Date of Birth ____/____/____

Please Circle: Male Female

DENTAL INFORMATION

Previous Dentist _____ Phone #: _____

Date of last dental exam: ____/____/____ Services Performed _____

Primary dental complaint: _____

How long have you had the above mentioned dental problems? _____

HEALTH INFORMATION

Please list all medication that you are currently taking (including prescription drugs, over-the-counter drugs, vitamins, inhalers, etc.)

ALLERGIES:

Please list each of the medications that you are allergic to, and the reaction that you had from taking the medication: _____

Please circle any of the following health conditions that apply to you:

Rheumatic Heart Disease/Fever	Asthma	Epilepsy/Convulsions	Nervous Disorders
Heart Disease	Emphysema	Heart Murmur	Bronchitis
Angina/MI	Chronic Cough	HIV	Hypertension
Shortness of Breath	Cancer	TB	Bleeding Disorders
Diabetes	Arthritis	Adrenal Disease	Peptic Ulcer Disorder
Artificial Joints	Hepatitis	Muscular Diseases	Renal Diseases
Thyroid Disease	Recent Surgeries	Smoker	Steroid Use
Other _____			

Are you pregnant/nursing or planning to become pregnant? ____ 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 condition.

I give my consent for the project coordinator to obtain information relevant to my eligibility for the DDS program from my physicians, dentists, individuals who know me and/or government or private agencies.

I give permission for the project coordinator to share pertinent information, about my eligibility, with one or more volunteer dentists in the DDS program. If my disability is AIDS or HIV related, I give the Virginia Dental Health Foundation (VDHF), which coordinates the DDS program, permission to release information about my medical condition and hold VDHF 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 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 DDS, 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 further understand that I am only eligible for services through the DDS program **one time**, and it is my responsibility to find follow-up dental care to maintain good oral health.

I understand the importance of keeping all scheduled appointments. Failure to do so (without at least 24 hours notice to the dentist) or the rescheduling of appointments, 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.

Note: I understand that any information concerning my case including any pictures or videos that I may appear in are the property of the DDS program (VDHF) and may be used in newsletter, brochures, journals, grant proposals, and other promotional materials.

Signature of applicant: _____ Date: ____/____/____

Signature of applicant's guardian: _____ Date: ____/____/____