



Wisconsin Dental
FOUNDATION

Donated Dental Services

Hello:

In response to your inquiry about the availability of free dental care, we are pleased to provide the following information about the Wisconsin Dental Foundation's Donated Dental Services(DDS) program.

ELIGIBILITY: Dentists throughout Wisconsin have volunteered to provide comprehensive dental care to people who because of permanent disability, chronic illness or advanced age(65+). Lack of income to pay for needed dental care is a secondary requirement.

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 application,
- Step Two when your application comes up for review, a referral coordinator will call
To obtain additional information,
- 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 place on our waiting list. Please be patient; due to the overwhelming response to our program, 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 hope the Donated Dental Services(DDS) program may be some source of help.

SOUTHEAST WISCONSIN: P.O. BOX 14173 • WEST ALLIS, WI 53214 • PH 414-755-4188 • TOLL FREE 888-338-6852
GREATER WISCONSIN: P.O. BOX 14173 • WEST ALLIS, WI 53214 • PH 414-755-4190 • TOLL FREE 866-812-9840
WWW.WDA.ORG

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Wisconsin Donated Dental Services
P.O. Box 14173
West Allis, WI 53214-0173
(888) 338-6852 or (866) 812-9840

APPLICANT

NAME: _____ PHONE: _____

ADDRESS: _____ PLEASE CIRCLE: MALE FEMALE

CITY, STATE, ZIP: _____ COUNTY: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

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?**

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 dentists in the DDS program. If my disability is AIDS or HIV related, I give the WDF-DDS program permission to release information about my medical condition and hold WDF 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 Wisconsin Dental Foundation, 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 the 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 referring person(if applicable) _____ Date: _____

Optional Photo and information Consent Form

"I give permission to the Wisconsin Dental Foundation DDS 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, media articles, advertisements or other marketing materials that promote the WDF-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 WDF-DDS program the right to copyright such material if necessary. **I understand that if I didn't grant 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: _____