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## Texas Donated Dental Services

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### PROGRAM ELIGIBILITY CRITERIA

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

**We can only accept those applicants who meet at least one of the following two criteria below, show that there is no other means of obtaining needed dental care and must be uninsured and are not eligible for any state dental health programs.**

1. Individuals who are 55 years or older.
2. Individuals who have a permanent debilitating disability.

**If you do not meet at least one of the two criteria above, then you do not qualify for services through the TXDDS program.**

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### COST OF PROGRAM

Dentist treatment and laboratory work is at no cost to qualifying individuals.

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### APPLICATION PROCEDURES

Step 1: Please complete, sign, and return the enclosed application to:  
Texas Dental Association Smiles Foundation  
Texas Donated Dental Services  
1946 South IH 35, Suite 300  
Austin, TX 78704



Step 2: **YOU SHOULD RECEIVE A POSTCARD IN THE MAIL VERIFYING THAT WE HAVE RECEIVED YOUR APPLICATION. IF YOU DO NOT RECEIVE A POSTCARD IN THE MAIL WITHIN ONE MONTH OF APPLYING, WE HAVE NOT RECEIVED YOUR APPLICATION AND YOU WILL NEED TO CALL OUR OFFICES TO REQUEST ANOTHER APPLICATION.**

Step 3: This program operates on a first come first serve basis. When your application reaches the top of the waiting list, a TXDDS caseworker will call to obtain additional information and begin the process of matching you with a dentist in your area, or if you do not meet the eligibility requirements you will be notified by mail.

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Upon receipt, your application will be placed on the waiting list. Please be patient; due to program limitations, and the number of applications we receive, we are not able to process each application as they are received.

**At this time our waiting list is over 3 years.** One of the program caseworkers will contact you when your application comes up for review. We are sorry that you are experiencing dental problems, and we hope that Texas Donated Dental Services may be a source for some help.

Sincerely,

A handwritten signature in black ink, appearing to read "Judith Gonzalez".

Judith Gonzalez

A handwritten signature in black ink, appearing to read "Andrew Robertson".

Andrew Robertson

**APPLICATION FOR TEXAS DONATED DENTAL SERVICES (TXDDS) PROGRAM**

Date of Application: \_\_\_\_\_

**APPLICANT INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single Sex:  Male or  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Divorced

Separated

Married

How will you get to appointments? \_\_\_\_\_

Please list other cities within traveling distance: \_\_\_\_\_

**If we do not have a volunteer dentist in your area, you will be required to travel to the nearest city to receive services through the TXDDS program.**

**Contact person (relative, friend, etc.)**

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**Number of people in your household: \_\_\_\_\_**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**MEDICAL INFORMATION**

List all major disabilities and health problems: \_\_\_\_\_

List medications you are taking: \_\_\_\_\_

Do you take medication for high blood pressure/hypertension?  yes or  no

Do you require pre-medication?  yes or  no If yes, for which of the following:

Heart murmur

Joint replacement

Mitral valve prolapse

Other - please explain \_\_\_\_\_

Do you require wheelchair access?  yes or  no

Do you use any tobacco products?  yes or  no If yes, How many per week? \_\_\_\_\_

Do you receive Medicaid?  yes or  no If yes, Medicaid # \_\_\_\_\_

If no, are you eligible to receive Medicaid benefits?  yes or  no If yes, please explain: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Physician's phone #: \_\_\_\_\_

Date of last physician appointment: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**FINANCIAL INFORMATION**

**MONTHLY INCOME FOR APPLICANT:**

Are you able to work? yes or no

If no, please explain: \_\_\_\_\_

Are you employed? yes or no Place of employment: \_\_\_\_\_

Your monthly wages: \$ \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

\_\_\_\_\_

**MONTHLY INCOME FOR ADDITIONAL HOUSEHOLD MEMBERS:**

Do you live with your spouse, parent(s), or child over 25? yes or no

Are they employed or receiving public assistance? yes or no

Place of employment or type of public assistance: \_\_\_\_\_

Monthly wages or amount of public assistance: \$ \_\_\_\_\_

If they are unemployed, why? \_\_\_\_\_

**PUBLIC ASSISTANCE FOR APPLICANT:**

Do you receive public assistance? yes or no ---- If yes, please fill out below

<u>Programs</u>	<u>Monthly amount</u>	<u>How long have you received benefits?</u>
<input type="checkbox"/> SSI	\$ _____	_____
<input type="checkbox"/> Social Security Disability	\$ _____	_____
<input type="checkbox"/> AFDC	\$ _____	_____
<input type="checkbox"/> Social Security	\$ _____	_____
<input type="checkbox"/> TANF	\$ _____	_____
<input type="checkbox"/> Unemployment	\$ _____	_____
<input type="checkbox"/> Other:	\$ _____	_____

**TOTAL MONTHLY HOUSEHOLD INCOME: \$ \_\_\_\_\_ (include all other household members)**

Do you have any savings? \_\_\_\_\_

If yes, total amount of savings: \_\_\_\_\_

Total value of investments: \_\_\_\_\_

Type of investments: \_\_\_\_\_

Do you receive food stamps? yes or no

If yes, monthly amount: \_\_\_\_\_

**MONTHLY EXPENSES:**

Housing: \$ \_\_\_\_\_ Gas/electricity: \$ \_\_\_\_\_ Water/sewer: \$ \_\_\_\_\_

Phone: \$ \_\_\_\_\_ Food (not including food stamps) \$ \_\_\_\_\_ House items: \$ \_\_\_\_\_

Health ins.: \$ \_\_\_\_\_ Life/burial ins.: \$ \_\_\_\_\_ Cable: \$ \_\_\_\_\_

Medications: \$ \_\_\_\_\_ Medical costs: \$ \_\_\_\_\_ Credit card(s): \$ \_\_\_\_\_

Do you own a car? yes or no

Do you currently have a car payment? yes or no

Car payment: \$ \_\_\_\_\_ Car insurance: \$ \_\_\_\_\_ Gas/car exp: \$ \_\_\_\_\_

Pay-off date: \_\_\_\_\_ Make, model, and year of car: \_\_\_\_\_

Other: \_\_\_\_\_

**TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ \_\_\_\_\_ (include all household expenses)**



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**MEDICAL RELEASE FORM**

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**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 TXDDS 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 TXDDS program. If my disability is AIDS or HIV related, I give Texas Dental Association Smiles Foundation (TDASF) permission to release information about my medical condition and hold TDASF harmless for doing so.

**I realize that application to the TXDDS 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 Texas Dental Association Smiles Foundation, which coordinates the TXDDS 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 only treat my existing dental condition and are not obligated to provide donated care in the future or to retain me as a patient.

I understand that importance of keeping all scheduled appointments. Failure to do so, without at least a 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:** \_\_\_\_\_

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

**Date:** \_\_\_\_\_

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**SEND APPLICATION TO:**

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Texas Dental Association Smiles Foundation  
**Texas Donated Dental Services (TXDDS)**  
1946 South IH 35, Suite 300  
Austin, TX 78704  
877-807-6453