



APPLICATION FOR OPTIONS PROGRAM

**Dental OPTIONS
246 N. High Street
Columbus, Ohio 43215
1-888-765-6789**

Name _____ Phone (____) _____

Street Address _____ Sex (circle) Male Female

City, Zip Code _____ County _____

Age _____ Date of Birth _____ *Social Security Number _____

Race (circle) White African Hispanic American Indian/ Asian/
American Alaskan Native Pacific Islander

Marital Status (circle) Single Married Divorced Widowed Separated

How long have you lived at the address above? _____ months _____ years

Number of people in the household _____ Please list below.

**Applying for
OPTIONS?**

Yes	No	Name	Date of Birth	Relationship	Soc. Sec. No.	Race
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Contact person not living with you: _____

Phone: (____) _____ Relationship to you: _____

Complete address: _____

How did you hear about the Dental OPTIONS Program? _____

Major disabilities or health problems (explain in as much detail as possible): _____

Family doctor's name: _____ Phone: (____) _____

Do you require wheelchair access (circle)? Yes No

*Disclosure of a social security number is voluntary and will be used to identify patients enrolled in the Dental OPTIONS Program. Social security numbers will be kept confidential and will not be released without approval of the applicant. Pursuant to Revised Code 3701.027, refusal to provide a social security number will not affect eligibility.

SOURCES OF INCOME/PUBLIC ASSISTANCE

MONTHLY INCOME FOR HOUSEHOLD:

Are you employed (circle)? Yes No Place of employment _____

Monthly wages \$ _____ (gross pay, before taxes are taken out)

If unemployed, why? _____

Anyone else in the household employed (circle)? Yes No Place of employment _____

Monthly wages \$ _____ (gross pay, before taxes are taken out)

If other adults in household unemployed, why? _____

DOES YOUR HOUSEHOLD RECEIVE:

OTHER INCOME	MONTHLY AMOUNT	HOW LONG?
CHILD SUPPORT?		
PENSION/RETIREMENT?		
SSI?		
SSDI?		
TANF (ADC)?		
WORKER'S COMP?		
SOCIAL SECURITY?		
FOOD STAMPS?		
UNEMPLOYMENT?		
OTHER? (list source)		

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____

***** PLEASE SUBMIT PROOF (NOT ORIGINALS) FOR ALL INCOME LISTED ABOVE.
PROOF WILL NOT BE RETURNED TO YOU.**

SAVINGS

Total amount of savings account \$ _____

Total amount of investments \$ _____

Type of investment (IRA, money market account, etc.) _____

Make, model and year of car _____

INSURANCE INFORMATION

Do you receive Medicaid benefits (circle)? Yes No

Do you have dental insurance (circle)? Yes No

If yes, name of insurer and number _____

MONTHLY EXPENSES FOR HOUSEHOLD

Housing \$ _____	Phone \$ _____	Food \$ _____
Gas/Electricity \$ _____	Water/Sewer \$ _____	Car payment \$ _____
Car insurance \$ _____	Gas/Car expense \$ _____	Health insurance \$ _____
Life/Burial insurance \$ _____	Medications \$ _____	Medical cost \$ _____
Child support \$ _____	Credit cards \$ _____	Day care \$ _____
Other \$ _____	Other \$ _____	Other \$ _____

TOTAL MONTHLY HOUSEHOLD EXPENSES \$ _____

DENTAL NEEDS

Briefly describe dental needs _____

Name of last dentist you saw _____ Phone(____) _____

Date of last dental visit _____ Reason _____

How will you get to your appointments (circle)? Yourself friend/relative bus/taxi

If friend/relative, name and phone _____ Phone (____) _____

ADDITIONAL INFORMATION

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

FOR YOUR APPLICATION TO BE CONSIDERED, YOU MUST:

- **COMPLETE ALL QUESTIONS. ALL QUESTIONS MUST BE ANSWERED.**
- **SUBMIT FINANCIAL INFORMATION FROM PREVIOUS PAGE.**
 - *PAY STUBS, W2 FORM, OR RECENT INCOME TAX RETURN
 - *PUBLIC ASSISTANCE PROOF
 - *AWARD LETTERS
 - *OTHER INCOME PROOF
- **SIGN THE BACK PAGE.**

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

FOR OFFICE USE ONLY:

Income _____ Family size _____

DDS DFA _____

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 conditions.

I give my consent for the Referral Coordinator to obtain information, relevant to my eligibility for the Dental OPTIONS 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 Dental OPTIONS Program.

I realize that application to the Dental OPTIONS 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 Dental OPTIONS Program Referral Coordinator 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 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/discounted care in the future or to maintain me as a patient.

The Dental OPTIONS Program (and its sponsoring organizations) serves as a referral source only. Dentists participating in the Dental OPTIONS Program shall not be considered agents of the Dental OPTIONS Program or its sponsoring organizations. The Dental OPTIONS Program (and its sponsoring organizations) does not investigate dentists who participate in the program and accepts no responsibility for the treatment provided by the dentists under the program.

I agree to submit any appropriate controversy or claim arising out of my treatment under the Dental OPTIONS Program to the Ohio Dental Association Peer Review Process.

I understand that if I am eligible for the Dental OPTIONS Program, I am responsible for paying the appropriate fee agreed to by the dentist and me.

I hereby authorize the Dental OPTIONS Program to collect and complete information from my dentist for all services rendered. I understand that the information will be used to gauge the success of the Dental OPTIONS Program and that specific information will be kept strictly confidential.

I understand the importance of keeping all scheduled appointments. Failure to do so 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 or Helping to complete application _____ **Date** _____

May we contact you for assistance in working with this client, if necessary? **Yes** **No**

Telephone number () _____