A PROGRAM OF THE
NATIONAL FOUNDATION OF DENTISTRY
FOR THE HANDICAPPED

*A charitable affiliate of the
American Dental Association*

P.O. Box 3710
Wilsonville, OR 97070
503/594-0837
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www.nfdh.org

OREGON DONATED DENTAL SERVICES (DDS)

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

ELIGIBILITY: Dentists throughout the state of Oregon have volunteered to provide comprehensive dental care at no charge to people of all ages who, because of a developmental disability, chronic mental illness, or advanced age, over 65 and lack adequate income nor have dental insurance to pay for needed dental care. There are no rigid financial eligibility requirements.

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 enclosed application,

Step Two — when your application comes up for review, a referral coordinator will call to obtain additional information (those who don't qualify will be told so during the call),

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. The treatment plan is decided by the dentist and you have the right to disagree, if you disagree we do not refer you to another dentist.

Upon receipt, your application will be placed on our waiting list. Please be patient; due to program limitations, we are not able to process each application as soon as it is received. Preference is given to people with Developmental Disabilities. The referral coordinator will contact you when your application comes up for review.

Sincerely,

Sue Lear
DDS Program Coordinator

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Oregon Donated Dental Services
PO Box 2240
Running springs, CA 92382
(877)357-8660

Date of Application:________________
Have you received services from the 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 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: ____

TOTAL MONTHLY HOUSEHOLD INCOME: $__________________________

TOTAL VALUE OF SAVINGS:____

TOTAL VALUE AND 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:____

TOTAL MONTHLY HOUSEHOLD EXPENSES: $_________________

DENTAL PROBLEMS

BRIEFLY DESCRIBE YOUR DENTAL PROBLEMS:____

____

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:_______