

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

PENNSYLVANIA DONATED DENTAL SERVICES
C/O ACHD
907 WEST STREET, 2ND FLOOR ROOM 7
PITTSBURGH, PA 15221
(412) 243-4866 OR (888) 683-9158

DATE OF APPLICATION: _____
HAVE YOU RECEIVED SERVICES THROUGH
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

PRIMARY HEALTH INSURANCE: _____

SECONDARY HEALTH INSURANCE: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____

FINANCIAL INFORMATION

INCOME AND OTHER FINANCIAL RESOURCES:

WHAT IS YOUR TOTAL MONTHLY HOUSEHOLD 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? _____

IF YOU RECEIVE SOCIAL SECURITY BENEFITS, WHEN DID YOU BEGIN RECEIVING THIS BENEFIT?: _____

WHAT IS YOUR HOUSEHOLD INCOME FROM SOCIAL SECURITY AND/OR SSI? _____

DO YOU RECEIVE MEDICAID OR MEDICAL ASSISTANCE BENEFITS? ____ YES ____ NO

IF YES, WHAT IS YOUR ACCESS CARD /MEDICAID HMO # _____

DO YOU HAVE DENTAL INSURANCE? ____ YES ____ NO

VALUE OF SAVINGS AND INVESTMENTS _____

ARE ANY FAMILY MEMBERS ABLE TO CONTRIBUTE TO THE COST 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

EXPENSES

WHAT IS THE TOTAL AMOUNT OF YOUR MONTHLY 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: _____, _____,

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 from my physician, dentist, contact people I listed, and/or government or private agencies in order to determine my eligibility for the DDS program.

I understand information provided by me or others as noted above may be given only to the volunteers involved in my treatment and will be held confidential.

I give permission for the referral coordinator to share information about me 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 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, medical, 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 that 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: _____

