A PROGRAM OF THE
NATIONAL FOUNDATION OF DENTISTRY
FOR THE HANDICAPPED

*A charitable affiliate of the
American Dental Association*

c/o Seattle-King County Dental Society
2201 Sixth Avenue, Suite 1210
Seattle, WA 98121-1857
206/441-8777
Fax: 206/443-9308

DONATED DENTAL SERVICES (DDS)

In response to your recent inquiry about the availability of donated dental care, we have enclosed an application. ***Please keep this page*** as it covers the requirements, application procedures and other important details about our program.

Dentists in the Seattle area have volunteered to provide comprehensive dental care at no charge to **King County residents** who are unable to pay for needed dental care due to a disability, serious medical problem, advanced age or lack of income. Applicants may go through the program ***one time only*** and must have *extensive dental needs* that cannot be resolved through other available programs or resources.

Please note: Donated Dental Services depends on the goodwill and availability of volunteer dentists and labs. Donating dentists determine the diagnosis and make decisions on necessary treatment. Due to the high number of applicants, it usually takes 12 months or more to receive assistance. *Those who need immediate care or who only need basic dental work should call the Seattle King County Dental Society at 206-443-7607 for a list of low-cost dental clinics or get the list online at SKCDS.org.*

THE APPLICATION PROCESS

Step One: Please fill out the application as completely as possible, including financial income and expenses so that a preliminary determination of eligibility can be made. Remember to **sign and date** the application.

Step Two: Upon receipt, your application will be placed on our waiting list. *Please be patient.* When a dentist is available in your area, the referral coordinator will call to obtain additional information and make a final determination of eligibility.

Step Three: Your information will be shared with the available dentist and you will be contacted if the dentist agrees to see you for an initial examination. **Final acceptance** into the program will only be made after the clinical examination, after the specific treatment needs are established.

We are sorry you are experiencing a dental problem and we hope the Donated Dental Services (DDS) program may be a source of some help.

Sincerely,

Debra Blake
DDS Program Coordinator

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

RETURN COMPLETED AND SIGNED APPLICATION TO:

SEATTLE DONATED DENTAL SERVICES
PO BOX 2641
VASHON, WA 98070-2641
206-441-8777

DATE OF APPLICATION:_______________
HAVE YOU RECEIVED SERVICES THROUGH DDS PROGRAM BEFORE?___YES ___NO

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 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.

In addition, I understand if my disability is AIDS or HIV related, I give the referral coordinator of the Foundation of Dentistry for the Handicapped (FDH) permission to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS program and hold FDH harmless for doing so. I also understand that I have a right to revoke this consent at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it. Furthermore, this consent will expire by _________ or upon __________.

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 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:________