MISSOURI 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 in Missouri have volunteered to provide comprehensive dental care at no charge to people of all ages who, because of a serious disability, advanced age, or medical problems, lack adequate income to pay for needed dental care. There are no rigid financial eligibility requirements. Applicants must need more than routine care in order to qualify.

COST: There is generally no cost to qualifying individuals; occasionally, 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.

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. The referral coordinator will contact you when your application comes up for review.

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,

Teena Paris
DDS Program Coordinator
APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

DATE OF APPLICATION: ________________

MISSOURI DONATED DENTAL SERVICES
P.O. BOX 6848
JEFFERSON CITY, MO 65102
(573) 635-9988
(866) 792-9988

HAVE YOU APPLIED SERVICES THROUGH
THE DDS PROGRAM BEFORE? ____ YES ____ NO

APPLICANT

NAME: ___________________________ PHONE: ___________________________

ADDRESS: ______________________________________________________________________________________

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  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:

AFDC:

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: $__________________________

Page 2 of 4
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: ________________________________ Date: ______