



480-850-1474  
866-340-4337

## DONATED DENTAL SERVICES

3193 N. Drinkwater  
Scottsdale, AZ 85251  
www.azda.org

Thank you for 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 Arizona have volunteered to provide comprehensive dental care at no charge to *individuals who are elderly (65+), have a special need (SSDI), or are medically compromised (i.e., transplant waiting lists)*, and lack adequate income to pay for needed dental care or have no dental insurance.

**COST:** There is generally no cost for qualifying individuals. On occasion, individuals in a position to pay for part of their care are encouraged to do so, especially when laboratory work or hospitalization is involved.

**EXPECTATIONS:** Understand that we do not offer free “smile makeovers”. *This program is designed to restore your teeth to acceptable function and design and may be limited in scope of care. We do not offer implants or cover hospitalization.*

### APPLICATION PROCEDURES:

- Step One** 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.

Because of the extensive screening process, please **understand that this program cannot respond to emergency requests.** Also, because of the overwhelming demand for free dental services we are not able to process each application immediately. Upon receipt, your application will be placed on our waiting list -- **waiting lists in some areas may exceed two years.**

Be patient, the referral coordinator will contact you when your application comes up for review. However, we recommend that you continue to seek treatment through local resources while you are on the waiting list – specifically we recommend using the hygiene schools to keep any oral disease under control.

If you feel your case is urgent or you do not fit our criteria, refer to the enclosed clinic referral list or log onto [www.findadentist4.me](http://www.findadentist4.me) and select the criteria specific to your needs (i.e., senior discounts).

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

Sincerely,

DDS Program Coordinator  
480-850-1474 / 866-340-4337

Rvsd. 05/10

**PLEASE KEEP THIS COVER LETTER FOR YOUR FUTURE REFERENCE**

**APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM**

DONATED DENTAL SERVICES  
3193 N DRINKWATER  
SCOTTSDALE, AZ 85251  
(480) 850-1474 / (866) 340-4337

DATE OF APPLICATION: \_\_\_\_\_  
HAVE YOU APPLIED BEFORE? \_\_\_\_\_

**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: \_\_\_\_\_

AFDC: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

UNEMPLOYMENT: \_\_\_\_\_

OTHER: \_\_\_\_\_

TOTAL MONTHLY HOUSEHOLD INCOME: \$ \_\_\_\_\_

TOTAL VALUE OF SAVINGS: \_\_\_\_\_

TOTAL VALUE OF INVESTMENTS: \_\_\_\_\_

TYPE OF INVESTMENTS: \_\_\_\_\_

FOOD STAMPS? \_\_\_YES \_\_\_NO IF YES, 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 TRAVEL TO: \_\_\_\_\_

DO YOU RECEIVE AHCCCS/MEDICAID BENEFITS? \_\_\_\_YES \_\_\_\_NO

IF YES, 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 Arizona Dental Foundation permission to release information about my medical condition and hold ADF harmless for doing so.

I realize that an 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 Arizona Dental Foundation, 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: \_\_\_\_\_ Date: \_\_\_\_\_  
(if necessary)

Signature of person referring (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_