



3193 N. Drinkwater
Scottsdale, AZ 85251

Hello:

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 medical compromised (transplant waiting lists), and lack adequate income to pay for needed dental care or have no dental insurance.

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 or hospitalization is involved.

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. 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 one year. Please be patient, 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,

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

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 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: _____ Date: _____
(if necessary)

Signature of person referring (if applicable): _____ Date: _____