Dental Lifeline Network • Michigan
More than Dentistry. Life.®
Michigan Donated Dental Services (DDS)

3657 Okemos Road, Suite 200
Okemos, MI 48864-3927
Southeastern Michigan:
Phone: 517.347.0054
Rest of State:
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www.DentalLifeline.org

In Partnership with
Michigan Dental Association

DONATED DENTAL SERVICES (DDS)

Dear Applicant:

In response to your request for more information regarding how to apply for donated dental care, we are pleased to provide the following information and application for the Donated Dental Services Program (DDS), a program of Dental Lifeline Network • Michigan.

ELIGIBILITY:

Dentists in Michigan have volunteered to provide comprehensive dental care at no charge to people of all ages who are permanently disabled, elderly or medically fragile and lack adequate income to pay for needed dental care.

COST:

Qualifying individuals generally pay nothing, but occasionally, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is necessary.

DENTAL BENEFITS:

If dental insurance and/or Medicaid cover any portion of your dental problems, you will be asked to exhaust this resource.

APPLICATION PROCESS:

Step One
Complete entire application. Page 5 of the application provides consent for the Program Coordinator to obtain and share information about you and provides consent for your physician to release medical information. Please return the application and both consent forms by mail, fax, or online as directed.

Step Two
When your application is received and you appear to be eligible for DDS, your application will be placed on a waitlist in the order it was received. If you are not eligible, a letter of denial will be sent to you. **Depending upon the area you live in, the wait will be several months or can be over a year. Please also be aware that we cannot return phone calls about where you are on the waiting list due to the volume of calls we receive and trying to help people through the program as quickly as possible.**

Step Three
When your application comes to the top of the waitlist, DDS will contact you to tentatively determine eligibility. If a volunteer dentist agrees to evaluate your oral health, you will be given the information to schedule a consultation. **Final acceptance** into the program will be made only **after** the consultation and when the specific treatment needs are established by a volunteer dentist.

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

Sincerely,
Donated Dental Services (DDS) Program Coordinator

Please keep this page for your records.

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Donated Dental Services (DDS)
3657 Okemos Rd., Suite 200
Okemos, MI 48864

For Internal Use Only:

Application ID: _____ Date entered: _____

Circle One: C D T Date: _____

Date of application: _____

APPLICANT INFORMATION

Name: _____ Phone: (_____) _____ (home)

Address: _____ Phone: (_____) _____ (cell)

City: _____ State: _____ Zip Code: _____ County: _____

Email Address: _____

Date of birth: _____ Age: _____ Male: ☐ Female: ☐ Military Veteran: ☐

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Contact Person Name (relative, friend, etc.): _____

Phone: (_____) _____ Relationship to you: _____

Have you received services through the DDS program before? Yes ☐ No ☐ If yes, in which state? _____

How did you hear about the DDS program? _____

MEDICAL INFORMATION (*if you answer yes to any of the questions below please take page 6 of this application to your doctor and have them fill it out. Attach the completed form to your application when you submit it*)

Do you have an artificial heart valve and/or stent? Yes ☐ No ☐ Do you have osteoporosis? Yes ☐ No ☐

Do you receive treatment for heart problems? Yes ☐ No ☐ Do you have rheumatoid arthritis? Yes ☐ No ☐

Are you currently on dialysis? Yes ☐ No ☐ Do you have Lupus? Yes ☐ No ☐

Do you have Crohn's disease? Yes ☐ No ☐ Do you have Multiple Sclerosis? Yes ☐ No ☐

Have you ever had an organ transplant? Yes ☐ No ☐ Do you take Clozaril? Yes ☐ No ☐

Are you currently being treated for cancer? Yes ☐ No ☐

Do you have an artificial joint or other orthopedic hardware? Yes ☐ No ☐

Have you taken any of the following medications; Boniva, Prolia, Fosamax, Reclast, Actonel, Interferon? Yes ☐ No ☐

Has your physician advised you that you need dental care immediately due to a medical condition? Yes ☐ No ☐

Major Disabilities or Health Problems (if your health problem is listed above please explain all in as much detail as possible, also include health problems not listed above):

_____

_____

_____

_____

_____

Primary Physician's name:_____

Phone: (_____)_____ Fax: (_____)_____

Do you use a: Wheelchair: ☐ Cane: ☐ Walker: ☐ Scooter: ☐

Do you require wheelchair access? Yes: ☐ No: ☐

DENTAL INFORMATION

Briefly describe your dental problems: _____

_____

How many natural teeth do you have remaining? # of Upper Teeth:_____ # of Lower Teeth:_____

Name of last dentist:_____Phone: (_____)_____

Approximate date of last dental visit:_____

How will you get to dental appointments?_____

Please list other cities or how far you are willing to travel in order to get dental treatment:_____

_____

REFERRING AGENCY or AGENCY THROUGH WHICH YOU RECEIVE SERVICES

Agency name:_____

Name of caseworker:_____Phone: (_____)_____

Address:_____Fax: (_____)_____

City:_____ State:_____ Zip:_____

HOUSEHOLD FINANCIAL INFORMATION

Number of people in your household:

Name of each person in the household:	Age:	Relationship to you:	Monthly Income:

MONTHLY HOUSEHOLD INCOME:

Are you able to work? Yes: ☐ No: ☐

If no, please explain why:_____

If you are employed, place of employment:_____

Your monthly employment income: $_____

Is your spouse/significant other employed? Yes: ☐ No: ☐

If no, please explain why:_____

If they are employed, Place of employment:_____

Spouse's/significant other's monthly employment income: $_____

FINANCIAL ASSISTANCE: Monthly amount: Year benefit began:

SSI or SSDI Payments: $_____ _____

Social Security (retirement): $_____ _____

Unemployment/Workers Compensation: $_____ _____

Temporary assistance to needy families (TANF): $_____ _____

Other Public Assistance:_____ $_____ _____

Total Monthly Household Income: $_____

If you are not receiving disability, have you ever applied? Yes: ☐ No: ☐

Total value of savings: $_____

Pension: $_____

Type of investments/assets: _____

Total value of investments/assets: $_____

Do you receive Food Stamps? Yes: ☐ No: ☐ Monthly amount: $_____

Do you receive Medicaid benefits? Yes: ☐ No: ☐ Medicaid #:_____

Do you receive Medicare benefits? Yes: ☐ No: ☐

Do you have a Medicare Advantage Plan? Yes: ☐ No: ☐

Do you have dental insurance? Yes: ☐ No: ☐

MONTHLY HOUSEHOLD EXPENSES:

Housing: $_____ Own: ☐ Rent: ☐

Food (not including Food Stamps): $_____ Utilities: $_____ Phone: $_____

Cable/Internet: $_____ Credit card/Loan payments: $_____ Medications/Medical Costs: $_____

Out of pocket health insurance: $_____ Life/Burial insurance: $_____

Is there a car in the household? Yes: ☐ No: ☐

If yes, make: _____ model: _____ year of car: _____

Car payment: $_____ Car insurance/Car expenses/Gas: $_____

Other Monthly Expenses: _____

Total Monthly Household Expenses: $_____

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: _____

_____

ADDITIONAL INFORMATION:

Use this space to elaborate on any information not sufficiently explained in other areas:

_____

_____

_____

AGREEMENT

Please read the following statements
If you understand and agree to the conditions, please sign and date at the bottom of the form

1. Agreement – Release of Information

a. I understand that I will need to provide personal information that includes but, is not limited to medical, dental, and financial condition. I authorize the DDS Program to obtain information from, and share information with my physician(s), dentist(s), contact people I listed, and/or government or private agencies in order to determine my eligibility for the DDS program.

b. 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 authorize the DDS Program to share information with and obtain information about me with one or more dentist(s) volunteering in the DDS program.

c. I understand if my disability is AIDS or HIV related, I authorize the DDS Program and Dental Lifeline Network • Michigan to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS program and hold Dental Lifeline Network • Michigan 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 _____.

2. Eligibility & Treatment Understanding

a. I realize that my 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 Dental Lifeline Network • Michigan, which coordinates the DDS program, will determine whether I am eligible for the program and, if so, will try to refer me to a participating volunteer dentist. I further understand that the dentist, not the organization, is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

b. I understand that the dentist(s) has volunteered to treat my existing dental condition only and is not obligated to provide donated care in the future or to maintain me as a patient.

c. I understand that a volunteer dentist in the DDS program may discontinue providing services to me at any time upon reasonable notice provided to me. I understand that, after receiving such notice, I am responsible for obtaining the services of an alternate dentist. I also understand that the Dental Lifeline Network • Michigan has no responsibility to assist me in obtaining the services of an alternate dentist.

3. My Responsibilities

I understand the importance of keeping all scheduled appointments and agree to make them.

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:_____

4. Optional Photo and Information Consent Form

I authorize Dental Lifeline Network • Michigan 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 organization 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 organization 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:_____

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RELEASE OF INFORMATION & AUTHORIZATION

I,_____ __/____/____
Client First Name Middle Initial Last *Date of Birth*

Authorize Dental Lifeline Network • Michigan to obtain information from and share information with:

_____
Name of Medical Provider/Hospital/Person/Agency Address City, State, Zip

Client is seeking care through the Dental Lifeline Network • Michigan (DLN) Donated Dental Services (DDS) program, a humanitarian initiative through which volunteer dentists and laboratories provide comprehensive dental care without charge for individuals with mental, physical, and/or medical disabilities. Information about the Client will be used to better understand the relative clinical circumstances and needs of applicant, and the possible medical necessity and urgency for dental treatment.

Please print clearly.

- I understand and authorize the release of medical and personal information about me for purposes of receiving comprehensive dental treatment through the DDS Program.
- I understand that if I do not sign this authorization that DLN may withhold treatment or eligibility for the DDS program.
- I understand that there is potential for information disclosed, as a result of this release/authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.
- I understand that I may revoke this release/authorization at any time by giving written notice to DLN, except to the extent that action has already been taken to comply with it. Without such revocation this release/authorization will expire on _____/_____/_____, or if left blank, one year from the date of my signature. Any revocation of authorization will prevent me from further treatment through the DDS program.
- I understand that I have a right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

_____ _____
Signature of Client/Legal Representative *Relationship to Client*

_____ _____
Address City, State, Zip *Date*

NOTICE TO WHOM THIS INFORMATION IS GIVEN: this information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/authorization.

DO NOT sign below unless you wish to revoke your consent for release of information.

I hereby revoke this Consent to Release/Authorization for Information.

_____ _____
Signature of Client/Legal Representative *Relationship to Client*

_____
Date

Donated Dental Services (DDS) - Medical Triage Form

Only submit this form with your application if you have a medical need for dental treatment.

MUST BE COMPLETED BY YOUR MEDICAL DOCTOR! Date: _____

_____ _____
Printed Name of Physician Physician Signature

_____ _____
Patient Full Name Physician Phone Number

Oral Condition (please check applicable line):
Severity of disease: ___ mild (no obvious decay or periodontal infections)
___moderate (obvious decay and/or periodontal disease but not extreme)
___severe (rampant decay, teeth fractured and/or mobile, significant periodontal inflammation)
___other (please describe _____)

Medical Condition (please check all applicable lines):
Organ transplantation: ___ candidate for, or ___ recipient of a transplant (organ_____)

Immunodeficiency: __ immune system suppressed by medication and/or disease (specify_____)

Renal function: ___ compromised (___ on or planned hemodialysis)

Medications: __ corticosteroids, ___immunosuppressive or cytotoxic drugs,
___bisphonphonate therapy __ planned / __ active / __ completed (how long ago _____).
Please specify medication(s), and in following parentheses the related condition for which the drug is prescribed; e.g., remicade (rheumatoid arthritis): _____

Diabetes: __ type 1 / __type 2 / __ controlled with __ diet, __ medication / __poorly or uncontrolled

Cancer: _____ type / ___active, ___ in remission
__chemotherapy and/or radiation therapy is __planned, __ active, __ completed

Cardiovascular: __ hx of bacterial endocarditis / __ artificial heart value / __ stent / __ valvular heart disease

__other (please specify _____)

Blood dyscrasia: __ (please specify type and severity) _____

Joint prosthesis: ___ planned / ___ present (type_____)

Medical Necessity of Dental Care
Will medical therapies for the patient be complicated by untreated oral condition?
__ yes / __ no

If yes, please check applicable medical management issues
___ Enhanced immuno-suppression concerns / risks
___ Sepsis Risks preventing or delaying needed surgery / type _____
___ Concerns regarding intubation for anesthesia or endoscopy because teeth are mobile or brittle
___ Other (please describe _____)

Given medical circumstance(s), are you concerned the person's dental condition poses a significant risk of increased morbidity?
__ yes / __no

If yes, please grade risk: ___ Moderate, needs dental care completed within six to twelve months
___ Severe, needs dental care within three to six months
___ Urgent, present status an unacceptable risk to overall care (eg. abscesses, ostemyelitis)