AAO Donated Orthodontic Services Program

1800 15th Street, Suite 100 · Denver, Colorado 80202 · (866) 201-5906 phone · 303.534.5290 fax

In response to your recent inquiry about the availability of free or low-cost Orthodontic care, we are pleased to provide the following information about the Donated Orthodontic Services (DOS) program.

Orthodontists throughout the country have volunteered to provide orthodontic care to low income children.

Eligibility

- Patients must be between the ages of 8-18 (depending on the state where the patient lives) when they begin treatment.

- Patients cannot already be in braces or in between phases of orthodontic treatment.

- Patients must be receiving regular dental care and have good oral hygiene.

- Total family income must be below 200% of federal poverty level.

- Patient must be ineligible for orthodontic treatment through insurance or public aid.

- If determined eligible, a coordination fee of $200 must be received by the Donated Orthodontic Services (DOS) Program BEFORE the initial visit with the volunteer orthodontist.

Step One: **Please complete, sign and return the enclosed application, along with a copy of the items below:**

- **Last year's federal tax return for the household or Social Security award letter.**
- **Completed dentist referral form that is enclosed; to be completed by the child's regular dentist.**
- **A letter from the child explaining why he/she wants the braces and how he/she intends to care for them.**
- **All information MUST be included in order for an application to be considered.**

Step Two: You will then be placed on our waiting list. Waiting lists vary anywhere from 3-18 months, depending on the area.

Step Three: When your application comes up for review, a referral coordinator will call to obtain any additional required information (those who do not qualify will be told so during the call).

Step Four: The referral coordinator will share the information about the patient who is tentatively accepted with a volunteer orthodontist.

Step Five: You will be notified of the orthodontist'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 initial clinical examination when the specific treatment needs are established.

Step Six: Applicants determined eligible will be responsible for a fee of $200 to Donated Orthodontic Services (DOS). This money does not go to the orthodontist, as he/she is solely volunteering his/her time. This fee covers processing applications and the coordination of care. The fee will be collected BEFORE the child has seen the orthodontist.

Upon receipt of your completed application, the applicant will be placed on a 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.

Application for Donated Orthodontic Services (DOS) Program

Donated Orthodontic Services   Date of Application:
1800 15th Street, Suite 100
Denver, CO 80202
(866) 201-5906
(303) 534-5290 - Fax

Applicant:

Child's Name:_____

Parent or Guardian's Name: _____ Phone:_

Address:_____

Please Circle: Male   Female

City, State, Zip:_____ County:_____

Child's Date of birth: _____ Age: _____

Email Address: _____

Preferred Form of Communication (Please Circle): Phone   Email   Mail

How did you hear about the DOS program? _____

Contact person (relative, friend, etc.):

Name: _____ Phone: _____

Relationship to child: _____

Number of people in child's household: _____

<u>Name of each person</u>   <u>Age</u>   <u>Relationship to child</u>

_____

_____

_____

_____

_____

Financial Information

Household Monthly Income:

Parent or Guardian #1_____

Are you employed? ___Yes ___NO   Place of Employment: _____

Your monthly wages: $_____

Parent or Guardian #2_____

Are you employed? ___Yes ___NO   Place of Employment: _____

Your monthly wages: $_____

Are there any other sources of income for your household, such as social security, ssi, tanf, unemployment, child support, etc.)? If so, please indicate below

_____

_____

_____

TOTAL MONTHLY HOUSEHOLD INCOME FROM ALL SOURCES: $_____

Total value of child's & parent(s) savings:_____

Total value of child's & parent(s) investments:_____

Parent or guardian must submit a copy of last year's federal tax return or SSI awards letter with this application.

Does the child receive Medicaid benefits? ____yes ____no Medicaid # _____

Does the child have dental insurance? ____yes ____no

Dental Needs

Briefly describe the child's dental needs:_____

Does your child have a dentist? _____

If yes, Name of dentist: _____ Phone#_____

Date of last dental visit:_____

Has a dentist recommended braces for your child? _____

Do any other members of your family have braces, receive orthodontic care, or received care in the past? _____   If so, when? _____

How will you ensure your child gets to dental appointments? _____

Please list other towns you can get to:_____,

_____,_____,_____

Additional Information

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

_____

_____

_____

Parent or guardian must be willing to adhere to Donated Orthodontic Services rules; the patient must:

- Have regular dental visits during the course of orthodontic treatment;
- Maintain good oral hygiene;
- Keep all regularly scheduled appointments
- Take proper care of all orthodontic appliances;
- Comply with all instructions given by orthodontist

I have read the above expectations and if applicant is selected to be a patient in the program, I will ensure that the conditions above are met.

Signature of parent or guardian: _____ Date:_____

(Please also sign the release on page 8)

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 child's physician, dentist, contact people I listed, and/or government or private agencies in order to determine their eligibility for the DOS program.

I understand information provided by me or others as noted above may be given only to the volunteers involved in my child's treatment and will be held confidential.

I give permission for the referral coordinator to share information about my child with one or more volunteer dentists in the DOS program.

I realize that the application to the DOS program does <u>not</u> assure my child will be referred for an examination or that they will be accepted as a patient following an examination.

I understand that Dental Lifeline Network, which coordinates the DOS program, will determine whether my child is eligible for the program and, if so, will seek to refer my child to a participating volunteer orthodontist. I further understand that the orthodontist, <u>not</u> Dental Lifeline Network, is solely responsible for diagnosis and any possible treatment that my child might receive for their dental needs.

I understand that the orthodontist has volunteered to treat my child's existing dental condition only and are not obligated to provide donated care in the future or to maintain my child 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 my child 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 parent or guardian: _____   Date: _____

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

<u>Optional Photo and Information Consent Form</u>

"I give permission to Dental Lifeline Network to use my child's 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 Dental Lifeline Network 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 Dental Lifeline Network the right to copyright such material if necessary.

 I understand that if I don't grant this permission, it will *not* affect my child's eligibility for receiving services through Donated Orthodontic Services (DOS)."

Signature of parent or guardian: _____ Date:_____

Donated Orthodontic Services

Program Patient Rules

1. Donated Orthodontic Services (DOS) provides for orthodontic treatment only. Extractions, dental cleanings, oral surgery, periodontal therapy, and any other treatment that may be necessary before, during, or after orthodontic treatment are the financial responsibility of the patient's parents or legal guardians. This treatment may be sought through public aid as well.

2. If your child has cavities or periodontal disease (gum disease), these conditions must be completely remedied before orthodontic treatment begins.

3. Your child must have a general dentist, who must verify that all necessary dental treatment has been completed before orthodontic treatment begins. In addition, your child must maintain regular dental appointments and cleanings during orthodontic treatment.

4. During the course of treatment, if your child does not brush and floss their teeth properly, cavities can form around the braces. If your child does not maintain proper oral hygiene or if cavities form which are not remedied, the treating orthodontist has the option to remove the braces and end the orthodontic treatment. Your child will then be dismissed from the DOS Program.

5. If your child is accepted into the DOS Program, orthodontic treatment will be provided by the assigned orthodontist only. If you move away from the treating orthodontist, the DOS Coordinator will attempt to find your child another treating orthodontist; however DOS cannot guarantee that this will be possible. If you move before the orthodontic treatment finishes and DOS is unable to find a new orthodontist, you must advise your treating orthodontist and make any arrangements necessary to complete treatment, including finding a new orthodontist, which will become your financial responsibility, or having the current orthodontist remove the braces.

6. Regular orthodontic appointments are necessary to make sure the teeth move as expected and no unwanted movement occurs. Most of these appointments will be during school hours. It is your responsibility to make sure that all of the scheduled appointments are kept. Failure to maintain regularly scheduled appointments on a continued basis is grounds for the treating orthodontist to remove the braces and end the orthodontic treatment.

7. You and your child must completely follow the treatment plan recommended by your orthodontist, which will be explained to you before orthodontic treatment begins. If you fail to follow the treatment plan, the treating orthodontist has the option to refuse to continue treatment, to remove the braces, and to end the orthodontic treatment.

8. During the course of orthodontic treatment, your child must cooperate with the assigned orthodontist. Failure to cooperate fully with the orthodontist or to maintain proper behavior so that the treatment can be delivered can result in the orthodontist refusing to continue orthodontic treatment until the improper behavior is corrected or removing the braces and ending treatment.

9. Broken appliances or loose brackets and bands can cause damage to the teeth and the rest of the mouth. Your child must take special care not to eat hard or sticky foods or pull on the braces. If there is frequent damage to the braces, the treating orthodontist has the option of removing the braces or charging you to repair the damage, which is not covered by the DOS Program.

10. One retainer, which is necessary to keep the teeth from shifting, will be provided as part of orthodontic treatment at no charge. If the retainer is damaged or lost, you will be charged for a replacement retainer.

Signature of parent or guardian: _____

Date: _____

Signature of patient: _____

Date: _____