Hello:
In response to your recent inquiry about the availability of free dental care, we are pleased to provide the following information about the Donated Dental Services Program.

ELIGIBILITY: Dentists throughout the state have volunteered to provide comprehensive dental care at no charge to people of all ages, who, because of a serious disability of impaired mental and/or physical health, lack adequate income to pay for needed dental care. All patients admitted into the program must have transportation to the dental office and must keep all appointments. The Donated Dental Services Program is unable to provide sedation services for simple procedures, such as x-rays and cleanings. Dental services are provided free of charge to eligible individuals.

APPLICATION PROCEDURES:
Step One: Please complete, sign, and return the enclosed application.
Step Two: When your application has come up for review, a patient-care coordinator will call to obtain additional information. Please do not call to check on the status of your application. These phone calls take up much of our time and only delay treatment time for all of our clients. A coordinator will call you when your application is up for review.
Step Three: The patient-care coordinator will send a referral with the patient’s information to a volunteer dentist.
Step Four: You will be contacted by a dentist’s office to schedule an appointment. It is very important that you do not miss any appointments or arrive late. Failure to keep appointments and be on time will result in termination from program.

Upon receipt, your application will be placed on our waiting list. Please be patient. Due to program limitations, we now have an 18-24 month waiting list in some counties. Therefore, we are unable to provide emergency care. The patient care coordinator will contact you when your application has come up for review.

Sincerely,

Lilian Marsh
DDS Executive Director

Chip Newton
Patient Care Coordinator

Joyce Prange
Patient Care Coordinator

Nancy Albrecht
Patient Care Coordinator

Please include a copy of your SSI/SSDI award letter with this application.

Revised
7/25/14
Maryland Foundation of Dentistry for the Handicapped – Application for Services

6410 Dobbin Road, Suite F
Columbia, Maryland 21045

Phone: 410-964-1944
1-877-337-7746
Fax: 410-964-9978

REFERRING AGENCY – IF APPLICABLE

Agency Name: _________________________________________________________________
Phone: (____)______________Name of Caseworker:___________________________________
Address: ______________________________________________________________________
City, State & Zip: _______________________________________________________________

APPLICANT:

Name: Mr. Mrs. Ms. ___________________________________________________________
Social Security #: _______________________________ Date of Birth____________________
Address: ______________________________________________________________________
City, State & Zip: ____________________________________ County: ___________________
Home Telephone: (____)_________________ Cell Telephone: (____)__________________
Number of Individuals in Household: ________ Means of Transportation: _________________

MAJOR DISABILITIES OR HEALTH PROBLEMS:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
List of Current Medications with Dosages and Frequency of Use: _________________________
________________________________________________________________________________
________________________________________________________________________________

Please check box if you have had any problems with the following:
☐ Heart    ☐ Kidneys    ☐ Liver    ☐ Allergies to Medications
Please provide explanation if you checked any of the above boxes:
________________________________________________________________________________
________________________________________________________________________________
Please list all major hospitalizations and dates:
________________________________________________________________________________
________________________________________________________________________________

Is the applicant able to work: ______ yes _____ no   If yes, please list current employer and job
responsibilities:
________________________________________________________________________________
________________________________________________________________________________

Does the applicant require wheelchair access: ______ yes ________ no
Primary Physician’s Name: ___________________________ Phone #: (____) _____________

Specialists Physician’s Name: ___________________________ Phone #: (____) _____________

**DENTAL NEEDS:**

Briefly describe applicant’s dental needs:

__________________________________________________________________________________

__________________________________________________________________________

Name of last dentist: _______________________________ Phone #: (____) ________________

Date of last dental visit: _____________ Services performed: ____________________________

**FINANCIAL INFORMATION:**

Is the applicant employed? ____ yes  ____ no  Monthly wages: $___________

Is spouse employed?        _____ yes ____ no  Monthly wages: $___________

Income from Social Services – Public Assistance             $___________

Income from: SSI SSDI PENSION OTHER (CIRCLE ALL THAT APPLY)   $___________

Total Monthly Household Income:                           $___________

Does the applicant receive food stamps? ____yes   ____ no        Amount:  $___________

Total Value of Savings/Investments:                      $___________

Does the applicant have Medical Assistance?  ____yes   ____ no

Please list your medical insurance provider, your policy number and their customer service number (located on the back of your insurance card):

______________________________________________________________________________

______________________________________________________________________________

Does the applicant have any dental insurance?  ________ yes  ________ no

If yes, please explain dental coverage: ________________________________

**MONTHLY EXPENSES:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>$_______</td>
</tr>
<tr>
<td>Phone</td>
<td>$_______</td>
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<tr>
<td>Food</td>
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<td>Utilities</td>
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<td>Water</td>
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<td>Medications</td>
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<tr>
<td>Car Payment</td>
<td>$_______</td>
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<td>Car Insurance</td>
<td>$_______</td>
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<tr>
<td>Gas/car expense</td>
<td>$_______</td>
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<tr>
<td>Health Insurance</td>
<td>$_______</td>
</tr>
<tr>
<td>Other</td>
<td>$_______</td>
</tr>
</tbody>
</table>

Total Monthly Household Expenses: $_________________

Does the applicant own a car?  _____ yes  ____ no  Make, model and year of car: ____________

Are family members able to contribute to applicants’ dental costs?   ______ yes  _______ no
CONSENTS:
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 conditions.

I give my consent for the 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 to the coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the DDS Program.

I realize that application to the DDS program does not ensure I will be referred for an examination or that I will be accepted as a patient following examination. I understand that the Maryland Foundation of Dentistry for the Handicapped, which coordinates the Donated Dental Services 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.

In understand that the dentist(s) have volunteered to treat my existing dental condition and are not obligated to provide donated care in the future or to maintain me as a patient.

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hours notice to the dentist, and will disqualify me for obtaining further dental 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 Guardian: _____________________________  Date: _____________

Optional Photo and Information Consent Form:
“I give permission to the MD Foundation of Dentistry for the Handicapped to use my name information, statements, or photograph for public relations purpose, 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 _____________

Revised 2/10/14