**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, advanced age, or medical problems, lack adequate income to pay for needed dental care. There are no rigid financial eligibility requirements.

**COST:** There is generally no cost to qualifying individuals; however, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is involved.

**APPLICATION PROCEDURES:**

- **Step One** please 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.

Upon receipt, your application will be placed on our 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.

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.
APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

DONATED DENTAL SERVICES
P.O. BOX 16854
ALBUQUERQUE, NM 87191
PHONE: (505) 298-7206 OR TOLL FREE AT (866)263-0671

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:

OTHER:

TOTAL MONTHLY HOUSEHOLD INCOME: $________________________

TOTAL VALUE OF SAVINGS:

TOTAL VALUE OF INVESTMENTS:

TYPE OF INVESTMENTS:

FOOD STAMPS? _____ YES _____ NO  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 GET TO: __________________________, ________________________, __________________________, __________________________.

DO YOU RECEIVE MEDICAID BENEFITS? _____ YES _____ NO  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 New Mexico Dental Foundation (NMDF) permission to release information about my medical condition and hold NMDF 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 New Mexico 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: ________