In response to your recent inquiry about the availability of free and low-cost dental care, we are pleased to provide the following information about the Texas Donated Dental Services (TXDDS) Program.

**PROGRAM CRITERIA**

We can only accept those applicants who meet at least one of the following two criteria below, show that there is no other means of obtaining needed dental care, and are uninsured and not eligible for any state dental health programs.

1. Individuals who are 62 years or older.
2. Individuals who have a permanent disability and receive disability benefits. *(Please note that proof of disability is required with completed application. As proof, we will accept your approved disability letter, a copy of your disability check stub, or a written letter from your physician, stating that you are permanently disabled, on their company letterhead. If proof is not submitted with your application, you will be automatically denied.)*

If you do not meet at least one of the two criteria above, then you do not qualify for services through the TXDDS program.

**GUIDELINES**

1. You must be on time for ALL of your appointments.
2. If you cannot make an appointment, you must call the dentist's office at least 24 hours in advance to cancel it.
3. If you miss ANY appointment without calling at least 24 hours in advance, you will be terminated from the program.
4. The dental treatment plan will be determined by the volunteer dentist. If you do not accept the treatment plan, you have the option to drop out of the program, but the treatment plan will not be changed.
5. You must be respectful to the volunteer dentist and their office staff. Any inappropriate behavior will be grounds for termination.
6. The TXDDS program's main goal is to improve the oral health of our patients and not solely for cosmetic reasons. Therefore dental implants, veneers, and bleaching are usually not included in treatment plans.
7. The dentist(s) have volunteered to only treat existing dental conditions and are not obligated to provide donated care in the future or to retain you as a patient.

**COST OF PROGRAM**

Texas Donated Dental Services is a program of the Texas Dental Association Smiles Foundation, a non-profit organization, and we are honored to help serve your current dental needs at no charge to qualifying individuals; this is not a government program. All volunteer dentists donate their time and they do not get paid for the services provided.

**APPLICATION PROCEDURES**

Step 1: Please complete, sign, and return the enclosed application to the TXDDS office. *(Address on last page)*

Step 2: A postcard will be placed in the mail when your application has been processed. All applications are processed once a month at the end of every month. If you do not receive a response within 6 weeks from the date you sent the application, please resubmit your application.

Step 3: This program operates on a first-come, first-serve basis. When your application reaches the top of the waiting list, a TXDDS caseworker will call to obtain additional information and begin the process of matching you with a dentist in your area. If you do not meet the eligibility requirements you will be notified by mail.

**Due to overwhelming demand, the waiting list at this time is approximately 1 year long.** The Program Coordinator will contact you when your application comes up for review. We understand your urgency, and are sorry that you are experiencing dental problems, and we hope that Texas Donated Dental Services may be a source for some help.

Happy, healthy smiles…
that's our mission!

Traci Mondragon
Program Coordinator
512/448-2441
APPLICATION FOR TEXAS DONATED DENTAL SERVICES (TXDDS) PROGRAM

Date of Application: ____/____/____

QUALIFICATION – Please Check ONE box below:

___ I am over the age of 62 years. I do not have the means of obtaining dental care. I do not have dental insurance. I am not eligible for any state dental health programs.

___ I have a permanent disability and cannot obtain employment. I do not have the means of obtaining dental care, and I am uninsured for dental and not eligible for any state dental health programs. I have enclosed documentation as proof of my disability.

(Please note that proof of disability is required with completed application. As proof, we will accept your approved disability letter, a copy of your disability check stub, or a written letter from your physician, stating that you are permanently disabled, on their company letterhead. If proof is not submitted with your application, you will be automatically denied.)

APPLICANT INFORMATION

Name: ___________________________ Phone: ___________________________

Address: ___________________________ Email address: ___________________________

City, State, Zip: ___________________________ County: ___________________________

Date of birth: ____/____/____ Age: _____ Social Security #: ___________________________

Marital Status: □ Single □ Divorced Gender: □ Male □ Female Height: _____ Weight: _____

□ Separated □ Married

How will you get to your appointments?

Please list other cities you are willing and able to travel to:

If we do not have a volunteer dentist in your area, you will be required to travel to receive services through the TXDDS program.

Contact person (relative, friend, etc.)

1. Name: ___________________________ Phone #: ___________________________ Relationship to you: ___________________________

2. Name: ___________________________ Phone #: ___________________________ Relationship to you: ___________________________

Number of people in your household: ______

1. Name: ___________________________ Age: _____ Relationship to you: ___________________________

2. Name: ___________________________ Age: _____ Relationship to you: ___________________________

3. Name: ___________________________ Age: _____ Relationship to you: ___________________________

4. Name: ___________________________ Age: _____ Relationship to you: ___________________________

5. Name: ___________________________ Age: _____ Relationship to you: ___________________________

MEDICAL INFORMATION

List all major disabilities and health problems: ___________________________

List medications you are taking: ___________________________

Do you take medication for high blood pressure/hypertension? □ yes □ no

Do you require pre-medication? □ yes □ no If yes, please explain: ___________________________

Do you require wheelchair access? □ yes □ no

Do you use any tobacco products? □ yes □ no If yes, Frequency? ___________________________

Do you receive Medicaid? □ yes □ no If yes, Medicaid # ___________________________

If no, are you eligible to receive Medicaid benefits? □ yes □ no If no, please explain: ___________________________

Physician's name: ___________________________ Physician's phone #: ___________________________

Date of last physician appointment: ___________________________ Reason for visit: ___________________________
FINANCIAL INFORMATION

MONTHLY INCOME FOR APPLICANT:

Are you able to work? □yes □no

If no, please explain: ____________________________________________________________

Are you employed? □yes □no Place of employment: ________________________________

Your monthly wages: $ ________________ Hours worked per week: __________________

MONTHLY INCOME FOR ADDITIONAL HOUSEHOLD MEMBERS:

Do you live with your spouse, significant other, parent(s), or child over 25? □yes □no

Are they employed or receiving public assistance? □yes □no

Place of employment or type of public assistance: ______________________________________

Monthly wages or amount of public assistance: $ ________________________________

If they are unemployed, why? _____________________________________________________

PUBLIC ASSISTANCE FOR APPLICANT:

Do you receive public assistance? □yes □no ---- If yes, please fill out below

<table>
<thead>
<tr>
<th>Programs</th>
<th>Monthly amount</th>
<th>How long have you received benefits?</th>
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<tbody>
<tr>
<td>□SSI</td>
<td>$</td>
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<tr>
<td>□Social Security Disability</td>
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<td>□AFDC</td>
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<td>□Unemployment</td>
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<tr>
<td>□Other:</td>
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</tbody>
</table>

TOTAL MONTHLY HOUSEHOLD INCOME: $ ________________ (include all other household members)

Do you have any savings? __________________________ If yes, total amount of savings: $ ______________

Do you receive food stamps? □yes or □no If yes, monthly amount: $ ______________

MONTHLY EXPENSES:

Housing: $ __________ Gas/electricity: $ __________ Water/sewer: $ __________

Phone: $ __________ Food (not including food stamps) $ __________ House items: $ __________

Health ins.: $ __________ Life/burial ins.: $ __________ Cable: $ __________

Medications: $ __________ Medical costs: $ __________ Credit card(s): $ __________

Do you own a car? □yes or □no Do you currently have a car payment? □yes or □no

Car payment: $ __________ Car insurance: $ __________ Gas/car exp: $ __________

Pay-off date: ______________ Make, model, and year of car: ____________________

Other: __________________________________________

TOTAL MONTHLY HOUSEHOLD EXPENSES: $ ________________ (include all household expenses)
DENTAL NEEDS

Please explain your dental problems:

________________________________________
________________________________________
________________________________________
________________________________________

Do you have dental insurance?  □ yes or □ no  If yes, please explain: __________________________________________

Do you need more than a cleaning?  □ yes or □ no  Please explain: __________________________________________

Do you need dentures/partials?  □ yes or □ no  Please explain: __________________________________________

Do you currently wear dentures/partials?  □ yes or □ no  How old are they? ____________________________

If yes, what problems do you currently have with your dentures/partials? __________________________________________

Name of last dentist: ____________________________  Phone#: ____________________________

Date of last dental visit: ____________________________  Reason for visit: ____________________________

Could you contribute financially toward the cost of your dental lab expenses?  □ yes or □ no

Are any family members able to contribute to costs of your dental treatment?  □ yes or □ no

If yes, please explain: __________________________________________  Amount of contribution: $ __________

Are any other sources available to help pay for dental care?  □ yes or □ no

If yes, please explain: __________________________________________

REFERRING AGENCY

How did you hear about the TXDDS program? __________________________________________

Agency name: ____________________________  Phone: (   ) ____________________________

Name of caseworker: ____________________________  Physician name: ____________________________

Address: ____________________________  City, State, Zip: ____________________________

ADDITIONAL INFORMATION

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

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Page 3 of 4
MEDICAL RELEASE FORM

Please read the following statements and initial each line, then sign and date at bottom of page

▼ Read each statement and Initial each blank.

____ I understand that I will need to provide personal information that includes, but is not limited to, medical, dental, and financial information to anyone involved in my dental treatment.

____ I give my consent to the Texas Dental Association Smiles Foundation (TDASF) to obtain information relevant to my eligibility for the TXDDS program from my physician, dentist, individuals who know me, and/or government or private agencies.

____ I give permission to the TDASF to share pertinent information about my eligibility with one or more volunteer dentists and/or labs in the TXDDS program. If my disability is AIDS or HIV related, I give TDASF permission to release information about my medical condition and hold TDASF harmless for doing so.

____ I realize that applying to the TXDDS program does not assure that I will be referred for an examination or that I will be accepted as a patient following an examination. I may be dropped at any time due to non-compliance with the program guidelines.

____ I understand that the Texas Dental Association Smiles Foundation, which coordinates the TXDDS 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 only treat my existing dental condition and are not obligated to provide donated care in the future or to retain me as a patient.

____ I understand that I must accept the treatment plan the volunteer dentist has decided for me. If I do not accept the treatment plan, I have the option to drop out of the program.

____ I understand that the TXDDS program is not intended to include implants, veneers, and bleaching in the treatment plan, it is the goal of TDASF to improve my oral health, and not solely for cosmetic reasons.

____ I understand that the TXDDS program can refuse dental services to anyone, at any time.

____ If I miss an appointment without a 24 hour notice, or if I’m disrespectful, argumentative, or conduct myself inappropriately at any time during the treatment, I understand that I will be automatically dropped from 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:__________________________

Signature of person referring (if applicable):_____________ Date:__________________________

PLEASE NOTE: Proof of your disability is required with completed application. As proof, we will accept your approved disability letter, a copy of your disability check stub or a written letter from your physician stating that you're permanently disabled on their company letterhead. If proof is not submitted with your application, you will be automatically denied.

SEND APPLICATION TO:

Texas Dental Association Smiles Foundation
Texas Donated Dental Services (TXDDS) Program
ATTN: Traci Mondragon
1946 South IH 35, Suite 300
Austin, TX 78704