Dental Lifeline Network • New Jersey
More than Dentistry. Life.®

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DONATED DENTAL SERVICES (DDS)

Dear Applicant:

The following pages are the Donated Dental Services (DDS) Program Application.

ELIGIBILITY:

Dentists in your state have volunteered to provide dental care. They do this for free to eligible applicants.

If you have a permanent disability, **or** over 65 years old, **or** medically compromised, and don't have enough money to pay for dental care, you may qualify for free treatment through the DDS program.

COST:

People who qualify usually pay nothing. Occasionally, people who can pay for part of their care may be asked to do so, especially if you need laboratory work.

DENTAL BENEFITS:

If you have dental insurance (including dental provided through Medicaid), you need to use that first.

APPLICATION PROCESS:

Step One
Complete entire application to the best of your ability.

Step Two
When we get your application, we will decide if you appear eligible for the program. If you appear eligible, we will put you on the waiting list in the order your application was received. If you are not eligible, we will send you a letter of denial. **Depending on where you live, the wait will be several months or can be over a year. We cannot return phone calls about where you are on the waiting list due to the volume of calls we receive.**

Step Three
When your application comes to the top of the waitlist, DDS will contact you. If the coordinator determines you are eligible, you will be referred to a volunteer. If a volunteer agrees to see you, you will schedule an appointment. **Final acceptance** into the program will be made only **after** the first appointment with the 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,

DDS Program Coordinator

Please keep this page for your records.

Frequently Asked Questions and Answers

1. **I have questions about how to fill out the application; who can I call?**
    - Do your best to complete as much as you can. Remember to sign page 4 of the application.
2. **How will I know if you received my application?**
    - A postcard will be mailed to you within a month of your application being received.
3. **How can I find out where I am on the waitlist or how long do I have to wait?**
    - I am sorry we are unable to answer this question. The waitlist is based on the number of volunteers in your area and how many people are already waiting for services.
4. **I have a dental emergency, can you help?**
    - We do not offer emergency treatment. When you become a patient of the program, it could take 4 weeks or longer to find you a dentist.
5. **How far will I have to travel?**
    - We will try to send you to a volunteer who is close to where you live.
6. **Where do I send my completed application?**
    - The mailing address and fax number are on page one at the top left corner.
7. **Who pays the dentists?**
    - Dentists are not paid by anyone. They have agreed to donate their time to treat our patients.
8. **What kind of dental work can I get through the DDS program?**
    - The dentist will come up with the treatment plan. The goal is to make sure you are pain-free and able to eat properly.
9. **Is there an income limit to get help?**
    - The program is here to help people who cannot afford the treatment they need. Each application will be reviewed to decide whether you qualify for dental care. If you believe you cannot afford your dental care, please apply.
10. **What should I write in the Referral Agency Section?**
    - Please give the name of the agency that gave you the application or the name of the agency that you go to for services.
11. **Who can fill out the Medical Triage form?**
    - Please take the Medical Triage form to your treating physician or nurse.
12. **Can I choose the dentist I go to?**
    - No. We match you with a dentist from the program who is located near where you live.

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Donated Dental Services (DDS)
PO Box 2117
Edison, NJ 08818

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 5 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 • New Jersey 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 • New Jersey 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 • New Jersey, 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 • New Jersey 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 • New Jersey 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:_____

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)