P.O. Box 14173
West Allis, WI 53214-0173
(888) 338-6852 – Southern and Eastern Wisconsin
(866) 812-9840 – Central and Northern Wisconsin

In response to your inquiry for more information regarding how to apply for donated dental care, we are pleased to provide the following information about the Wisconsin Dental Association Foundation's Donated Dental Services (DDS) program.

ELIGIBILITY: Dentists throughout Wisconsin have volunteered to provide dental care to people who because of permanent disability, chronic illness or advanced age (65+), lack income to pay for needed dental care. There are no rigid financial eligibility requirements; however, financial need is a major factor in the decision-making process. The DDS dentists donate their time and services; they are not paid by us or anyone else. When a DDS dentist decides to treat you, s/he determines the treatment plan. When the treatment plan is completed, your treatment with the DDS program ends as well. The dentist has no obligation to provide donated care in the future or to maintain you as a patient.

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 PROCEDURE:

Step One: Please complete entire application. Page 5 of the application provides consent for the Program Coordinator to obtain and share information about you and provides consent for your physician to release medical information. Please return the application and all consent forms by mail to the address listed on the application.
Step Two: When your application is received, if you are tentatively considered to be eligible for DDS, your application will be placed on a waiting list in the order in which it was received. If your application shows that you are definitely not eligible, a letter of denial will be sent to you. Depending upon the area in which you live, funding and volunteer availability, your wait can be as long as several months to over a year. If you require immediate or emergency care, you should seek it outside of the DDS program.
Step Three: When your application moves to the top of the waiting list, DDS staff will contact you to gather more information. When more information is made available, the coordinator will determine whether or not to contact a volunteer dentist. If a volunteer dentist agrees to evaluate your oral health, you will be given the information to schedule a consultation.
Final acceptance into the program will be made only after the consultation and when the specific treatment needs are established by a volunteer dentist.

We are sorry you are experiencing a dental problem and we hope the Donated Dental Services (DDS) program may be a source of help.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Mail application to:
Wisconsin Donated Dental Services
P.O. Box 14173
West Allis, WI 53214-0173
(888) 338-6852 – Southern and Eastern WI or (866) 812-9840

APPLICANT INFORMATION:

Name: ____________________ Phone: (______) ____________ (home)

Address: ____________________ Phone: (______) ____________ (cell)

City: ____________ State: ______ Zip Code: ________ County: ____________

How long at this address? Years ______ Months ______ Own ☐ Rent ☐

Social Security #: ____________________ 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? ____________________

HOUSEHOLD FINANCIAL INFORMATION:

Number of people in your household: _____

Name of each person in the household:	Age:	Relationship to you:	Monthly Income:

If you are not receiving disability, have you ever applied? Yes: ☐ No: ☐

MAJOR DISABILITIES OR HEALTH PROBLEMS
(Please explain in as much detail as possible. Please note that dental problems are not considered a disability.)

____

____

____

____

Primary Physician's name: ____________________

Phone: (______)____________ Date of Last Visit: ____________

Do you use a: Wheelchair ☐ Cane ☐ Walker ☐ Scooter ☐

Do you require wheelchair access? Yes ☐ No ☐

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: $________________

INCOME:

PROGRAM:	MONTHLY AMOUNT:	YEAR BENEFIT BEGAN?
SSI or SSDI	$ ________________	________________
Social Security Retirement	$ ________________	________________
Pension	$ ________________	________________
Unemployment/Worker's Compensation	$ ________________	________________
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/Electric	$ ____________	Water/Sewer	$ ____________	Car Payment	$ ____________
Car Insurance	$ ____________	Gas/Car Exp.	$ ____________	Health Insurance	$ ____________
Life/Burial Ins.	$ ____________	Medications	$ ____________	Medical Costs	$ ____________
Cigarettes	$ ____________	Cable/Satellite	$ ____________	House/Rent Ins.	$ ____________

Other $ ____________ Explain ______________________________
Examples: pets, internet, laundry, credit cards, etc.

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TOTAL MONTHLY HOUSEHOLD EXPENSES: $ ________________

REFERRING AGENCY or AGENCY THROUGH WHICH YOU RECEIVE SERVICES:

Agency name: ______________________________

Name of caseworker: ______________________________ Phone: (______)______________________________

Address: ______________________________ Fax: (_______)______________________________

City: ______________________________ State: ______________ Zip: ______________

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: ______________________ Services Performed ________________

____

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: ________________

____

Do you receive Medicaid benefits? Yes: ☐ No: ☐ Medicaid #: ____________________

Do you receive Medicare benefits? Yes: ☐ No: ☐

Do you have a Medicare Advantage Plan? Yes: ☐ No: ☐ Plan Name: ____________________

Do you have dental insurance? Yes: ☐ No: ☐

Is there a car(s) in the household? Yes: ☐ No: ☐

If yes, make: ____________________ model: ________________ year of car: ________

If yes, make: ____________________ model: ________________ year of car: ________

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:

____

____

____

____

OPTIONAL PHOTO AND INFORMATION CONSENT FORM:

I give permission to the WDA Foundation-DDS Program 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, media articles, advertisements or other marketing materials that promote the WDA Foundation-DDS Program 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 WDA Foundation-DDS Program the right to copyright such material if necessary. I understand that if I do not grant permission for the DDS Program to use my name, information, statements or photograph, it will *not* affect my eligibility for receiving services through the DDS Program.

Client's Signature (Required): ______________________________ Date: ______________

Signature of Client's Guardian (if needed): ______________________ Date: ______________

Signature of Referring Person (if applicable): ____________________ Date: ______________

Donated Dental Services Primary CONSENT Form

Please read this CONSENT form carefully. If you understand and agree to each of the conditions below, please sign and date the form where indicated to confirm your CONSENT to apply for the Donated Dental Services program ("DDS Program"), which is coordinated by the Wisconsin Dental Association Foundation ("WDA Foundation"). If you do not understand or agree with each of the specific conditions below, you should NOT sign this form or apply to participate in the DDS Program. Participation in the DDS Program is conditioned upon your agreement with and written CONSENT to the conditions below.

CONSENT TO USE MY PERSONAL INFORMATION - I understand that I will need to provide personal information that includes but is not limited to medical, dental, and information about my financial condition. Further, I give my consent for the referral coordinator to obtain my personal information from my physician, dentist, individuals who know me and/or government or private agencies that will be used to determine whether I may be eligible for the DDS Program. I also give my consent for the referral coordinator to share my personal information with one or more volunteer dentists in the DDS Program. If I have any disease or disability (including AIDS or HIV related issues), I give my consent to the WDA Foundation to release information about my medical condition and agree to hold the WDA Foundation harmless for doing so.

TREATMENT IS NOT GUARANTEED - l understand that my application to the DDS Program does not guarantee that I will receive treatment, be referred for an examination, or that I will be accepted as a patient following an examination, should an examination be completed. I understand and agree that the decision of the DDS Program is final and I agree to accept and be bound by that decision.

LIMITED SCOPE OF TREATMENT BY A VOLUNTEER DENTIST - I understand that the WDA Foundation, which coordinates the DDS Program, will determine whether I am eligible for the DDS Program and, if so, will seek to refer me to a participating volunteer dentist. I further understand that the volunteer dentist, not the WDA Foundation, is solely responsible for the diagnosis and dental treatment that I might receive.

I understand that the volunteer dentist has agreed to treat my existing dental condition only and is NOT obligated to provide donated dental care in the future or to keep me as a patient. Further, I understand that a volunteer dentist in the DDS Program may discontinue providing services to me at any time after providing notice to me. I understand that, after receiving such notice, if I wish to continue receiving dental treatment it will be my obligation to obtain services elsewhere. I understand that that the WDA Foundation – DDS Program has no responsibility to assist me in obtaining other dental services.

I understand that if I need immediate or emergency dental care, I should and will seek such treatment outside of the DDS Program.

I understand the importance of keeping all scheduled appointments, and that failure to do so, without at least 24 hour notice to the volunteer dentist, will disqualify me from obtaining further treatment through the DDS 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.

Client's Signature (Required): ______________________________ Date: ______________

Signature of Client's Guardian (if needed): ______________________________ Date: ______________

Signature of Referring Person (if applicable): ______________________________ Date: ______________

Donated Dental Services Primary RELEASE Form

Please read this RELEASE form carefully. If you understand and agree to each of the statements below, please sign and date the form where indicated to confirm your agreement to RELEASE the Wisconsin Dental Association Foundation (the "WDA Foundation"), which coordinates the Donated Dental Services program (the "DDS Program"). If you do not understand or agree with each of the statements below, you should NOT sign this RELEASE form or apply to participate in the DDS Program. Participation in the DDS Program is conditioned upon your written RELEASE of the WDA Foundation.

RELEASE OF THE WDA FOUNDATION FOR USE OF MY PERSONAL INFORMATION - I understand that I will need to provide personal information including but not limited to medical, dental, and information about my financial condition as a condition of applying to and participating in the DDS Program. I have consented to the use of my personal information in order to apply for and/or participate in the DDS Program. I hereby expressly RELEASE the WDA Foundation from any direct or indirect claim, demand or cause of action relating to or arising out of the use of my personal information for application to or participation in the DDS Program.

RELEASE OF THE WDA FOUNDATION FOR TREATMENT - I understand that the WDA 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 volunteer dentist, not the WDA Foundation, is solely responsible for the diagnosis and dental treatment that I might receive. I hereby expressly RELEASE the WDA Foundation from any claim, demand or cause of action relating to or arising out of the dental treatment I receive through participation in the DDS Program, including but not limited to any injury or damage resulting directly or indirectly related to treatment or failure to treat.

I acknowledge and agree that this RELEASE is freely given in exchange for the opportunity to apply to participate in the DDS Program.

To the best of my knowledge, the information provided to the DDS Program is a full and accurate disclosure of my current physical, mental and financial status.

Client's Signature (Required): ______________________________ Date: ______________

Signature of Client's Guardian (if needed): ______________________________ Date: ______________

Signature of Referring Person (if applicable): ______________________________ Date: ______________