



Donated Dental Services Program

PO Box 7018 : Pierre, SD 57501 : 866-551-8023

Dear Applicant:

Enclosed is a 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** are 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,

Brenda Goeden
DDS Program Manager

OVER

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 letter or 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. Because of the extensive waiting list in most areas of the state, it could take one year 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 is on the top of the application.

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. Can I choose the dentist I go to?

- No. We match you with a volunteer dentist from the program who is located near where you live.

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

S.D. Donated Dental Services
PO Box 7018
Pierre, SD 57501
FAX: 605-224-9168

APPLICANT INFORMATION

Name: _____ Phone: _____ (home)

Address: _____ Phone: _____ (cell)

City: _____ Zip Code: _____ County: _____

Email Address: _____

Date of Birth: _____ Age: _____ Male: Female:

Marital Status: Single Married Divorced Widowed

Contact Person Name (relative, friend, etc.): _____

Phone: (____) _____ Relationship to You: _____

Are you a veteran? Yes No If so, in what capacity did you serve? _____

If yes, are you eligible to receive dental benefits through the VA? Yes No

Are you eligible to receive dental benefits through the Indian Health Service (IHS)? Yes No

Number of people in your household: _____

Name of each person	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL INFORMATION

Major disabilities and/or health problems (explain in as much detail as possible. Do not include dental problems as part of this question): _____

Primary Physician's Name: _____

Phone: (____) _____ Fax: (____) _____

Psychiatrist's Name and phone number (if you have a mental disorder) _____

Do you use a: wheelchair cane walker scooter

FINANCIAL INFORMATION

Monthly Income:

Are you able to work outside the home? Yes No

If you are employed, place of employment: _____

Your monthly income: _____ Number of hours worked per week: _____

Is your spouse/significant other employed? Yes No

Place of employment: _____ Monthly Income: _____

If spouse/significant other is unemployed, why? _____

Financial Assistance:

Program	Monthly Amount
Social Security Disability (SSDI)	Enclose a copy of SSDI income statement(s)
Supplemental Security Income (SSI)	
Social Security (62 years or older)	
Temporary Assistance to Needy Families (TANF)	
Other	
Total Monthly Income:	

Total value of Savings: _____ Total value of Investments: _____

Food Stamps? Yes No Monthly Amount: \$ _____

Do you receive the following benefits? Medicaid Medicare

Do you have dental insurance? Yes No

Monthly Expenses

Housing: \$ _____ Own: Rent: Phone: \$ _____

Utilities: \$ _____ Cable/Internet: \$ _____

Food: \$ _____

Medications/Medical Costs: \$ _____ Out-of-Pocket Health Insurance: \$ _____

Credit card/Loan payments: \$ _____ Life/Health Insurance: \$ _____

Is there a car(s) in the household? Yes No If so, how many that run? _____

If yes, make(s): _____ Model(s): _____ Year(s): _____

Car payment(s): \$ _____ Car insurance/Car expenses/Gas: \$ _____

Other monthly expenses: \$ _____

Total monthly household expenses: \$ _____

DENTAL INFORMATION

Briefly describe your dental needs: _____

How many natural teeth do you have remaining? # Upper _____ # Lower _____

Name of Last Dentist: _____

Approximate date of last dental visit: _____

How will you get to your dental appointments: _____

Please list other cities or how far you are willing to travel in order to get dental treatment: _____

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 (churches, other agencies)? Yes No

If yes, please explain: _____

REFERRING AGENCY OR AGENCY YOU RECEIVE SERVICES THROUGH

Agency Name: _____

Name of Caseworker: _____ Phone: _____

Mailing Address: _____

Email Address: _____

ADDITIONAL INFORMATION:

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 me with one of more dentist(s) volunteering in the DDS Program.

C. I understand if my disability is AIDS or HIV-related, I authorize the DDS Program to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS Program and hold the DDS Program harmless in doing so. I also understand that I have a right to revoke 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. I understand that 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 Donated Dental Services Program 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 the Donated Dental Services 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(s), media articles, advertisements or other marketing materials that promote the 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 DDS Program the right to copyright such material if necessary. I understand that if I don't grant permission this permission, it will not affect my eligibility for receiving services through the DDS Program.

Signature of client: _____

Date: _____

Signature of client's guardian (if necessary) _____

Date: _____