



Hello:

In response to your recent inquiry about the availability of free dental care, we are pleased to provide the following information about the Donated Dental Services Program.

**ELIGIBILITY:** Dentists throughout the state of Maryland have volunteered to provide comprehensive dental care at no charge to people 18 years and older (including Veterans), who, because of a serious disability, impaired mental and/or physical health, lack adequate income to pay for needed dental care.

**Dental services are provided free of charge to eligible individuals. All patients admitted into the program must have transportation to the dental office and must keep all appointments. We are not emergency services and if you are accepted into the program, services are once in a lifetime, so after completion of treatment, you cannot apply again. Our program is unable to provide sedation services.**

**DENTAL BENEFITS:** If you have private dental insurance you are not eligible for this program.

**APPLICATION PROCEDURES:**

- Step One: Please complete, sign, and return the enclosed application. A patient care coordinator will call you when your application is up for review. Please call us at 410-964-1944 if you have any changes in your information, so we can update your application. Due to program limitations, we have a several month waiting list in some counties. **Please include a copy of your SSI/SSDI award letter with this application.**
- Step Two: When your application comes up for review, a patient care coordinator will call you to set up a phone interview and obtain additional information that will determine your eligibility for the program.
- Step Three: If you are accepted, the patient care coordinator will send a referral with your information to a volunteer dentist.
- Step Four: You will be contacted by the dentist's office to schedule an appointment. It is very important that you do not miss any appointments or arrive late. **Failure to keep appointments and be on time will result in termination from the program.**

If you have any questions, contact us at 410-964-1944.

Sincerely,

Marissa Tisch, MSW  
MFD Executive Director

Chip Newton  
Patient Care Coordinator (PCC)

Nikole Garland  
PCC

Leslie Howe  
PCC

## Maryland Foundation of Dentistry Application for Services

### REFERRING AGENCY – IF APPLICABLE

Agency Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Name of Caseworker: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

### APPLICANT:

Name: Mr. Mrs. Ms. \_\_\_\_\_

Race: \_\_\_\_\_ Social Security # (Last 4 digits only) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Cell Telephone: (\_\_\_\_) \_\_\_\_\_

Number of Individuals in Household: \_\_\_\_\_ Means of Transportation: \_\_\_\_\_

Does the applicant require wheelchair access: \_\_\_\_ yes \_\_\_\_ no Veteran Status: \_\_\_\_ yes \_\_\_\_ no

Does the applicant own a car? \_\_\_\_ yes \_\_\_\_ no Make, model and year of car: \_\_\_\_\_

Does the applicant have Medical Assistance? \_\_\_\_ yes \_\_\_\_ no Dental insurance? \_\_\_\_ yes \_\_\_\_ no

If yes, please explain dental coverage: \_\_\_\_\_

Please list your medical and dental insurance provider, your policy number and the customer service number (located on the back of your insurance card):  
\_\_\_\_\_

Is the applicant able to work?: \_\_\_\_ yes \_\_\_\_ no

If yes, please list current employer and job responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MAJOR DISABILITIES OR HEALTH PROBLEMS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List of current medications with dosages and frequency of use: (Please use an additional sheet if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check the boxes below if you have had (or have) problems with the following:

Heart      Kidneys      Liver      Allergies to Medications

Please provide an explanation if you checked any of the above boxes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all major hospitalizations and dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**DENTAL NEEDS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of last dentist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Services performed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL INFORMATION:**

Is the applicant employed? \_\_\_\_ yes \_\_\_\_ no Monthly wages: \$ \_\_\_\_\_

Is spouse/partner employed? \_\_\_\_ yes \_\_\_\_ no Monthly wages: \$ \_\_\_\_\_

Income from Social Services – Public Assistance \$ \_\_\_\_\_

Income from (**circle all that apply**): SSI SSDI Pension Other \$ \_\_\_\_\_

Total Monthly Household Income: \$ \_\_\_\_\_

Does the applicant receive food stamps? \_\_\_\_ yes \_\_\_\_ no Amount: \$ \_\_\_\_\_

Total Value of Savings/Investments: Amount: \$ \_\_\_\_\_

**MONTHLY EXPENSES:**

Housing \$ \_\_\_\_\_ Phone \$ \_\_\_\_\_ Food \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_ Water \$ \_\_\_\_\_ Medications \$ \_\_\_\_\_

Car Payment \$ \_\_\_\_\_ Car Insurance \$ \_\_\_\_\_ Gas/car expense \$ \_\_\_\_\_

Health Insurance \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Total Monthly Household Expenses: \$ \_\_\_\_\_

Are family members able to contribute to applicants' dental costs? \_\_\_\_ yes \_\_\_\_ no

Is there anything else you would like to add to your application?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENTS:**

**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 conditions.

I give my consent for the patient care 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 to the patient care coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the DDS Program.

I realize that application to the DDS program does not ensure I will be referred for an examination or that I will be accepted as a patient following examination. I understand that the Maryland Foundation of Dentistry (MFD), which coordinates the Donated Dental Services (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 MFD, 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 and are not obligated to provide donated care in the future or to maintain me as a patient.

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hours notice to the dentist, will disqualify me for obtaining further dental 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.

Name of Client (printed): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian/Power of Attorney: \_\_\_\_\_ Date: \_\_\_\_\_

**Optional Photo and Information Consent Form:**

I give permission to MFD 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 promotes the MFD program and encourages 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 MFD 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.**

Signature of Client: \_\_\_\_\_ Date \_\_\_\_\_

Guardian/Power of Attorney: \_\_\_\_\_ Date \_\_\_\_\_

Revised 5.11.2020