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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 free dental care.

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

### COST:

If you qualify, you may not need to pay for anything. From time to time, people who can pay for part of their care may be asked to do so, like when laboratory work is needed.

### DENTAL BENEFITS:

If you have dental insurance (even through Medicaid), you will need to use that first. Please provide a copy of your dental coverage and/or a letter of denial with your application.

### APPLICATION PROCESS:

#### Step One

Fill out the entire application the best that you can. Do not leave any sections blank. Please provide proof of income, and if you are disabled include proof of disability (e.g., SS Award Letter) with your application.

#### Step Two

When we get your application, we will decide if you appear eligible for the program. If so, 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.

**The wait will be several months or can be over a year in some areas. We cannot return phone calls about where you are on the waiting list.**

#### Step Three

When your application comes to the top of the waiting list, DDS will contact you and go over the application with you. If you are eligible, you will be referred to a volunteer dentist. If a volunteer agrees to see you, you will schedule an appointment. **Final acceptance** will be made **after** the first appointment with the dentist.

We are sorry you are having a dental problem. 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

- 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. When you are at the top of the waiting list, we will call you to review your 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 waiting list or how long I have to wait?**
  - We are unable to answer this question. The waiting list 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 are NOT able to offer emergency treatment due to the amount of people on our waiting list. In addition, once an applicant becomes an active patient, it can still take 4 weeks or longer to find a dentist.
- 5. How far will I have to travel?**
  - We will try to send you to a volunteer close to where you live.
- 6. Where do I send my completed application?**
  - The mailing address and fax number are on page one (1) of the application 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. The DDS program does not typically provide dental implants.
- 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 the program. 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; such as dialysis clinics, human services organizations, aging services, etc.
- 11. What does “Medically Triage” mean?**
  - Your doctor has told you that you need medically necessary dental care. Examples of such treatment includes needing dental clearance in order to receive a transplant, start chemo or neck/head radiation, surgery, starting new medications, etc.
  - If you fit within these criteria, your doctor will have to fill out a form stating that your dental issues are affecting your medical condition/s. The DDS Coordinator will send you a copy of the form once your application is received or it can be found on Page 6 of the hard-copy application.
- 12. Who can fill out the Medical Triage form?**
  - Please take the Medical Triage form to your treating physician or nurse.
- 13. 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)  
6110 N. Technology Center Dr. Suite 100  
Indianapolis, IN 46278  
Fax: 317.873.2489

### For Internal Use Only:

Application ID: \_\_\_\_\_ Date entered: \_\_\_\_\_  
Circle One: C D T Date: \_\_\_\_\_

Date of application: \_\_\_\_\_

### APPLICANT INFORMATION

Legal Name: \_\_\_\_\_ Pronouns (optional): \_\_\_\_\_  
Preferred Name (optional) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ (home)  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ (cell)  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Veteran: ☐ Branch: \_\_\_\_\_ (Provide DD-214)  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex at Birth: Male ☐ Female ☐ Other ☐  
Gender: Man ☐ Woman ☐ Transgender ☐ Non-Binary/Non-conforming ☐ Prefer not to answer/Other ☐  
Race: White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐  
Latinx ☐ Prefer not to answer ☐ Other ☐ \_\_\_\_\_  
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐  
Emergency Contact (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 ELIGIBILITY

Has your doctor mentioned that you must have medically-necessary dental care? (examples: In order to start a medication, receive a transplant, receive head/neck radiation, etc.) Yes ☐ No ☐ If Yes, please take page 6 of this application (Medical Triage Form) and have your physician fax it back to us.

**MAJOR DISABILITIES OR HEALTH PROBLEMS** (Please explain in as much detail as possible; include date diagnosed, symptoms, treatment, etc.):

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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 left?: # 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:\_\_\_\_\_

**Check all that apply:**

- ☐ Do you smoke?
- ☐ Do you use illicit drugs?
- ☐ Are you on Medications?
- ☐ Are you nervous about seeing a dentist?

**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:

<u>Name of each person in the household:</u>	<u>Age:</u>	<u>Relationship to you:</u>	<u>Monthly Income:</u>
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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**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 (*Provide copy of Award Letter*): \$ \_\_\_\_\_

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: ☐ Date Applied: \_\_\_\_\_

Total value of savings: \$ \_\_\_\_\_

Pension: \$ \_\_\_\_\_

Child Support: \$ \_\_\_\_\_

Type of investments/assets: \_\_\_\_\_

Total value of investments/assets: \$ \_\_\_\_\_

Do you receive SNAP or EBT Benefits? Yes: ☐ No: ☐ Monthly amount: \$ \_\_\_\_\_

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

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

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

Do you have dental insurance? Yes: ☐ No: ☐ (If Yes, Provide copy of Dental Benefits)

**MONTHLY HOUSEHOLD EXPENSES:**

Housing: \$ \_\_\_\_\_ Own: ☐ Rent: ☐ Taxes: \$ \_\_\_\_\_ Homeowner's insurance: \$ \_\_\_\_\_

Utilities: \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_ Cable/Internet: \$ \_\_\_\_\_

Groceries (food, paper, laundry, personal care): \$ \_\_\_\_\_ 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 Transportation costs: \$ \_\_\_\_\_

Child Care/Daycare: \$ \_\_\_\_\_ 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:

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**FOR YOUR APPLICATION TO BE CONSIDERED, YOU MUST:**

- Complete ALL questions. Incomplete applications will not be considered.
- Submit financial information: Pay stubs, W2 Form, Recent income Tax Return, Public assistance proof, Award Letters, Other income proof.
- Sign Page 4.

# AGREEMENT

Please read the following statements

If you understand and agree to the conditions please sign and date the form below

## 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 • Indiana 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 • Indiana harmless for doing so.
- d) 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 at either the termination or completion of my treatment through the DDS program.

## 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 • Indiana, 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 • Indiana has no responsibility to assist me in obtaining the services of an alternate dentist.

## My Responsibilities

- a) I agree to find and obtain reliable transportation to and from all dental appointments. Also, I agree to arrive on time to all of my appointments and will make every effort to arrive 15 minutes early prior to the time of my appointment.
- b) I agree to keep all appointments unless I have a serious emergency and rescheduling is unavoidable. If I have an emergency and I am unable to keep an appointment, I will follow the dentist's policy regarding cancellation and call the dentist's office to cancel my appointment at least 24-48 hours in advance. I understand that if I miss an appointment without calling in advance or reschedule or cancel more than one appointment, I may be terminated from the DDS program.
- c) I shall not ask the DDS volunteer dentist for pain medication and understand that medications will only be supplied or prescribed to me by the dentist when it is absolutely necessary and at the dentist's discretion.

**To the best of my knowledge, the information provided in this application is a full and accurate disclosure of my current physical, medical, and financial status and I agree to the terms and conditions stated above:**

Signature of client or client's guardian (if applicable): \_\_\_\_\_

Printed name of client: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*This form must be signed and dated prior to acceptance into the DDS program*



## Photo and Information Consent Form (Optional)

I authorize Dental Lifeline Network • Indiana 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 applicable): \_\_\_\_\_ Date: \_\_\_\_\_



## Dental Lifeline Network - Medical Triage Form

DLN is dedicated to helping people with disabilities, the elderly, or the medically fragile/compromised. We need your help to prioritize the dental needs of your patient.

Patient Name (**Printed**): \_\_\_\_\_

Program: IN-N

### Medical Necessity of Dental Care:

Given medical circumstance(s), are you concerned the person's dental condition poses a significant risk of increased morbidity?

☐ Yes\* ☐ No (**If the answer is no, do NOT proceed with the remainder of the form**)

*\*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 (i.e., abscesses, osteomyelitis)

### Medical Condition (*please check all applicable lines*):

- ☐ Sepsis concerns because patient is immunocompromised by:
  - ☐ Disease(s) (specify \_\_\_\_\_)
  - ☐ Immunosuppressant / Cytotoxic drugs (specify \_\_\_\_\_)
- ☐ Infection of existing or planned orthopedic prosthesis / hardware
- ☐ Infection of existing or planned implanted vascular / valvular / cardiac devices
- ☐ Recipient of or candidate for organ transplant (type \_\_\_\_\_) | Date of Transplant: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- ☐ Poorly managed diabetes (date and level of last A1C \_\_\_\_\_)
- ☐ History of endocarditis, valvular heart disease
- ☐ History or current use of bisphosphosphate drugs for cancer, osteoporosis (clarify if such drugs are
  - ☐ Planned, ☐ Currently being used, ☐ Completed (year discontinued \_\_\_\_\_)
- ☐ Recurrent pulmonary complications (infection, COPD, aspiration)
- ☐ Planned surgical, endoscopic, or intubation being postponed because of brittle / loose / infected teeth
- ☐ Dysphagia related to (disease \_\_\_\_\_) risking aspiration because of missing teeth and impaired mastication
- ☐ Serious risk that severe dental infection may create abscesses / dissecting cellulitis
- ☐ Patient requires recurrent use of antibiotics and/or opioid drugs because of unresolved dental infections
- ☐ Other \_\_\_\_\_

### 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 \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Stamp: