Dental Lifeline Network

1800 15th St. Suite 200
Denver, Co. 80202

Phone 801.499.6504
Fax 303.534.5290

www.Dentallifeline.org

Dental Lifeline Network (DLN)

Dear Applicant:

The following pages are the Dental Lifeline Network's 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 DLN'S 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. The Dentists providing the treatment are volunteers who are donating their services and are not compensated by DLN or any other entity. DLN and volunteer dentists are immune from civil liability pursuant to Illinois statute 745 ILCS 49/20 (a).

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 and send you a notification that your application was received.
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, we 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 that Dental Lifeline Network's program may be of some help.

Sincerely,

Dental Lifeline Network 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?**
   - An email or postcard will be sent 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 DLN's 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 DLN's 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 if I have dental insurance?**
    - You will have to exhaust your dental benefits prior to receiving care through the program. Please reach out to your dental insurance before applying to see if it will cover all or some of the services services needed.

11. **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.

12. **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 DLN's 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.

13. **Who can fill out the Medical Triage form?**
    - Please take the Medical Triage form to your <u>treating</u> physician or nurse.

14. **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 DENTAL LIFELINE NETWORK'S PROGRAM

Dental Lifeline Network

1800 15th St. Suite 200
Denver, Co. 80202
Fax
303.534.5290

For Internal Use Only:

Application ID: _____ Date entered: _____

Circle One: C D T Date: _____

APPLICANT INFORMATION

Date of application:_____

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 DLN's program before?Yes No If yes, in which state? _____

How did you hear about DLN's 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.):

_____

_____

_____

_____

_____

_____

_____

_____

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:

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 (*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:

_____

_____

_____

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 DLN's 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 DLN's 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 DLN's program to share information with and obtain information about me with one or more dentist(s) volunteering in DLN's program.

c) I understand if my disability is AIDS or HIV related, I authorize the Dental Lifeline Network to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists and hold Dental Lifeline Network 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 DLN's program.

Eligibility & Treatment Understanding

a) I realize that my application to DLN's 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, 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 DLN's 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 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 DLN's program.

c) I shall not ask DLN's 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

Dental Lifeline Network®

Photo and Information Consent Form (Optional)

I authorize Dental Lifeline Network 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, social media 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 Dental Lifeline Network's Program.

Signature of client:_____ Date:_____

Signature of client's guardian (if applicable):_____ Date:_____

PLEASE NOTE: This form should only be submitted if the Medical Eligibility question is marked "yes" on page one (1) of the application. This form *MUST BE COMPLETED BY YOUR TREATING MEDICAL PRACTITIONER*.

Dental Lifeline Network

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:

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 bisphosphate 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:

Please Return to: 1800 15th St. Suite 200 Denver, Co. 80202