In response to your recent inquiry about the availability of free or low-cost dental care, we are pleased to provide the following information about the Donated Dental Services (DDS) program.

Eligibility

Dentists throughout the state have volunteered to restore to good oral health elderly individuals who lack adequate income or resources to pay for needed dental care.

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 Procedures

- Step One: Please complete, sign, and return the enclosed application.
- Step Two: When your application comes up for a review, a referral coordinator will call to obtain additional information (those who don't qualify will be notified).
- Step Three: The referral coordinator will share the information about a person tentatively accepted with a volunteer dentist.
- Step Four: You will be notified of the dentist's name and phone number, and you will be responsible for scheduling an appointment for an examination. Final acceptance into the program will only be made after the clinical examination when the specific treatment needs are established.

If you have Medi-Cal benefits, or may be eligible, you must contact a dentist who accepts Medi-Cal near you. You can contact Medi-Cal to determine eligibility and locate a dentist at 800.322.6384.

Upon receipt, your application will be recorded and filed. Please be patient, due to program limitations, we are not able to process each application as soon as it is received. The referral coordinator will contact you when your application comes up for review.

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

Sincerely,

Tahira Bazile
DDS Program Administrator

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Donated Dental Services
Attn: Tahira Bazile
P.O. Box 13749
Sacramento, California 95853-4749
(800) 232-7645

APPLICANT

Name: ______________________________ Phone: ______________________

Address: ______________________________

City, State, Zip: ______________________________ County: ______________________

Date of Birth: ______________ Age: ________ Social Security #: ______________________

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

How did you hear about the DDS program? ______________________________

Contact Person (Relative, friend, etc.):

Name: ______________________________ Phone: ______________________

Relationship to You: ______________________________

Number of People in your Household: _________

Name of Each Person	Age	Relationship to You

Major Disabilities or Health Problems (Explain in as much detail as possible):

____

____

____

____

Do You Require Wheelchair Access: Yes _____ No _____

Physician's Name: ______________________________ Physician's Phone #: ______________________

FINANCIAL INFORMATION

MONTHLY INCOME:

Are You Able to Work: Yes _____ No _____

If No, Please Explain: ____

____

Are You Employed: Yes _____ No _____ Place of Employment: ____________________

Your Monthly Wages: $_______________

Is Your Spouse Employed: Yes _____ No _____ Place of Employment: ____________________

Spouses's Monthly Wages: $_______________

If Spouse is Unemployed, Why? ____

PUBLIC ASSISTANCE:

Program	Monthly Amount	How Long Have You Received Benefits?

SSI: ____

Social Security Disability: ____

Cal Works

Social Security: ____

Unemployment: ____

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 including Food Stamps): $_______________

Gas/Electricity: $_______________ Water/Sewer: $_______________ Car Payment: $_______________

Car Insurance: $_______________ Gas/Car Expense: $_______________ Health Insurance: $_______________

Life/Burial Insurance: $_______________ Medications: $_______________ Medical Costs: $_______________

Other: ____

Other: ____

TOTAL MONTHLY HOUSEHOLD EXPENSES: $______________________________

DENTAL NEEDS

Briefly Describe Your Dental Needs: ____

____

Name of Last Dentist: ______________________________ Phone: ____________________

Date of Last Dental Visit: ________________

How Will You Get to Dental Appointments: ____________________________________

Please List Other Towns You Can Get to: _____________________________________

____

Do You Receive MediCaid Benefits: Yes _____ No _____ MediCaid #____________________

Do You Have Dental Insurance: Yes _____ No _____

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, Services Organizations, Other Agencies, etc.): Yes _____ No _____

If Yes, Please Explain: ____

Do You Own a Car: Yes _____ No _____

Make, Model and Year of Car: ____

REFERRING AGENCY

Agency Name: ______________________________ Phone: ______________________

Name of Case Worker: __________________________

Address: __________________________________

City, State, Zip: ______________________________

ADDITIONAL INFORMATION

Use This Space to Elaborate on any Information Not Sufficiently Explained in Other Areas:

____

____

____

____

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 condition.

I give my consent for the referral 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 my permission for the referral coordinator to share pertinent information, about my eligibility, with one or more volunteer dentists in the DDS program. If my disability is AIDS or HIV related, I give the Foundation of Dentistry for the Handicapped (FDH) permission to release information about my medical condition and hold FDH harmless for doing so.

I realize that application to the DDS program does not assure I will be referred to an examination or that I will be accepted as a patient following an examination.

I understand that the Foundation of Dentistry for the Handicapped, 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 dentist, not the Foundation, 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 only 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-hour notice to the dentist, can and will disqualify me from obtaining further 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.

Signature of Client: ______________________________ Date: ______________

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

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

Optional Photo and Information Consent Form

"I give permission to the Foundation of Dentistry for the Handicapped and the California Dental Association (CDA) 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 both the Foundation and CDA and encourage involvement form dental professionals and funders. I also agree that no material needs to be submitted to me for any further approval, and I give both the Foundation and CDA 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 necessary): ____________________________ Date: ____________________