VDA Foundation VIRGINIA DENTAL ASSOCIATION | Donated Dental Services (DDS)

RETURN APPLICATION TO:
Donated Dental Services (DDS)
3460 Mayland Ct. Ste. 110
Richmond, VA 23233
FAX: 804-288-1880

APPLICANT INFORMATION

Name: _____ Phone: h) _____ c) _____

Address: _____

City: _____State:_____Zip:_____County (if applicable): _____

Email: (if available) _____

Date of Birth: _____/_____/_____ Age: _____ Please Note: __ Female __ Male

Military Veteran: __ Yes __ No

Marital Status: __ Single __ Married __ Divorced __ Widowed __ Separated __ In partnership

Race: __ Asian __ Black __ Hispanic __ Other __ Unknown __ White

Alternate Contact: _____ Relationship to you: _____

Phone: _____ Email: _____

How did you hear about our Program? Agency/Name: _____

Case Manager/Social Worker: _____Phone: _____

Should we contact your case manager/social worker about your application? _____ Yes _____ No

Email: _____Fax:_____

List the Names, Ages, and Incomes of ALL members of your household (Use the back of the page if needed)
Number of people living in your household: _____

Name of each person	**Age**	**Relationship to you**	**Monthly Income**

For office use only: *App #: _____*

Date Received _____/_____/_____ *Initial Status (Pending / Denied, reason _____)* *NLS _____/_____/_____*

Intake _____/_____/_____ *Closed _____/_____/_____* *Final Status (Closed / Terminated, reason _____)*

Updated February 23, 2024

HEALTH HISTORY- We may share the information you provide with a prospective volunteer dentist

Your Primary Care Physician's name: _____ Phone: _____

Please circle any of the health conditions that apply to you:

Adrenal Disease	Diabetes Type I	Mental Health Illness	_____
Artificial joints	Diabetes Type II	Peptic Ulcer	_____
Arthritis	Heart Disease	Renal Disease	_____
Asthma	Heart Murmur	Rheumatic Heart Disease/Fever	_____
Bleeding disorders	Hepatitis	Shortness of Breath	_____
Bronchitis/chronic cough	HIV/AIDS	Smoker	_____
Cancer	Hypertension	Recent Surgeries	_____

Please explain your major disabilities or health concerns:

_____

_____

Please list the medications you take: (prescriptions, over-the-counter, vitamins, inhalers, etc.):

_____

_____

Please list any medications you are allergic to, and the reaction you had from taking the medication:

_____

IF MORE ROOM IS NEEDED FOR ILLNESSES, MEDICATIONS, OR ALLERGIES, PLEASE ATTACH A SEPARATE SHEET OF PAPER

DENTAL INFORMATION

Previous Dentist: _____Phone:_____

Date of last exam: _____/_____/_____ Services Performed: _____

Tell us about your dental needs (*please be specific – number of teeth missing or present, how many issues?*):

Upper: _____

_____

Lower: _____

_____

Do you require wheelchair access? _____Yes _____No

Are you pregnant/nursing or planning to become pregnant? _____ Yes _____ No

FINANCIAL INFORMATION

Are you able to work? Part-time _____ Yes _____ No Full-time _____ Yes _____ No

If no, please explain

_____

_____

Are you employed: _____ Yes _____ No Monthly wages (before taxes):_____

Place of Employment:_____

Is your spouse employed? _____Yes _____ No Monthly wages: (before taxes) _____

Spouse's Place of Employment:_____

If your spouse is unemployed, please explain: _____

INCOME INFORMATION: *(your application is not complete until we receive proof of income documentation)*

Use $0 if you do not receive income from a source listed below.

TOTAL HOUSEHOLD INCOME (Not including your income) _____

YOUR SSDI/SSI: _____ *Date Started Receiving:* _____

SOCIAL SECURITY: _____ *Date Started Receiving:* _____

RETIREMENT _____ *Date Started Receiving:* _____

SNAP: _____ *Date Started Receiving:* _____

TANF: _____ *Date Started Receiving:* _____

UNEMPLOYMENT: _____ *Date Started Receiving:* _____

CHILD SUPPORT _____

OTHER INCOME: _____ *Source of Income:* _____

YOUR MONTHLY EXPENSES: *Housing: (Own or Rent)* _____ *Monthly Housing Expense:* _____

Phone: _____ *Utilities:* _____ *Cable/Internet:* _____

Food: (not including SNAP) _____ *Car Payments:* _____ *Car Insurance*:_____

Credit Cards/Loan Payments: _____ *Bus/other Transportation*: _____ *Gas:* _____

Health Insurance: _____ *Life/Burial Insurance:* _____

Medication: _____ *Other Medical costs:* _____ *Other:* _____

***TOTAL MONTHLY HOUSEHOLD EXPENSES**: $*_____

TRANSPORTATION

Having reliable transportation is a requirement for the Donated Dental Services program.

How will you get to your dental appointments? _____

Please list other towns you are able to get to easily _____, _____, _____

Can you drive to dental appointments? _____

Please Provide the Year, Make, and Model of Each Vehicle in your Household:

_____

_____

_____

_____

_____

INSURANCE

Do you receive Full Medicaid benefits? _____ Yes _____ No If yes, please list member # _____

(Note: If you receive Full Medicaid benefits, you may not be eligible for the DDS program.)

Do you receive Medicare benefits? _____ Yes _____ No

Do you have dental insurance? _____ Yes _____ No If yes, through what company? _____

Are you able to make payments toward your dental treatment? _____ Yes _____ No If yes, how much $ _____

Have you ever participated in the Donated Dental Services Program before? _____ Yes _____ No

Are there any other sources available to help pay for your dental care? (i.e. churches, service organizations, other agencies) _____ Yes _____ No If yes, please explain: _____

ADDITIONAL INFORMATION

How would this program help you, or impact your life?

_____

_____

_____

Is there anything else you would like to share with the volunteer dentists considering your case?

_____

_____

_____

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, SIGN AND DATE THE FORM AT THE BOTTOM. *WE WILL NOT CONSIDER YOUR APPLICATION WITHOUT A SIGNATURE BELOW.*

Regarding Information Sharing:

I understand I will need to provide personal information, which includes, but is not limited to medical, dental, and my financial condition.

I give my consent for the project coordinator to obtain information relevant to my eligibility for the Donated Dental Service (DDS) program from my physicians, dentists, individuals who know me, and/or government or private agencies.

I give permission for the project 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 Virginia Dental Association Foundation (VDAF), which coordinates the DDS program, permission to release information about my medical condition and hold VDAF harmless for doing so.

I realize applying 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 have provided a complete, accurate disclosure of my current physical and mental health as well as financial status on this application.

Please Note: Any information concerning my case, including pictures or videos in which I may appear, are the property of the Virginia Dental Association Foundation (VDAF), and may be used in newsletters, brochures, journals, grant proposals, or other promotional materials.

Regarding Treatment: ***(In the event that we are able to connect you with a dentist)***

I understand 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 the dentist, NOT DDS, is solely responsible for diagnosis and any possible treatment I might receive for my dental needs.

GOAL: To restore your mouth to good oral health

I understand that volunteers (dentists, their staffs, and labs) donate all services to you as a gift. Since services and materials (dentures, crowns, etc.) are donated, the most cost-effective manner will be taken without compromising quality. Cosmetic needs are not the focus. Living pain-free and being able to eat properly are what we are working towards.

I understand that the DDS Program may not cover implants, sedation, or certain types of extensive oral surgery. Unfortunately, we do not have access to hospitals where certain types of surgeries must be performed. **Certain cases are simply too complex for this program.**

I understand the dentist(s) have volunteered to treat my **existing dental condition only** and are not obligated to provide dental care in the future or to maintain me as a patient. I further understand I am only eligible for services through the DDS program ONE TIME, and it is my responsibility to find follow-up dental care to maintain good oral health.

I understand that the volunteer dentist will determine my treatment plan. Due to the limited number of volunteer dentists, Donated Dental Services will not reassign me to another dentist if I do not agree with the proposed treatment plan.

I am aware that at my first appointment, oral surgery or extractions may be part of my treatment.

Patient Responsibilities: ***Failure to adhere to any of these items may result in termination of your care.***

We must be able to communicate by phone and mail with you or an advocate throughout your care. We request that you notify us of any changes of address or phone while in our program.

You must have reliable transportation to get you to and from dental appointments on time; preferably 15 minutes early. At your first appointment, you may need to complete paperwork. We hope you will plan accordingly to allow enough time for that before your scheduled appointment.

If you must cancel or reschedule an appointment, then do so 24-48 hours or more in advance.

If you require help getting around the dental office or in and out of the chair, please bring someone with you to your appointment that can assist you. If you have difficulty hearing or speak a foreign language, please bring someone with you who can help you communicate with the dentist.

We hope you will discuss continual care of your teeth or dentures with your dentist prior to the end of your treatment. It is your responsibility to keep up with brushing, flossing, annual checkups, etc.

NOTE: We are not an emergency service. Please be prepared to wait for services. Some areas of Virginia could have as long as a 2 year wait for services. We will hold your application for 2 years from the date we receive it.

A SIGNATURE IS REQUIRED TO PROCESS THE APPLICATION.

Signature of Applicant: _____ Date: _____

Signature of Applicant's Guardian: _____ Date: _____