

Thank you for reaching out to the Donated Dental Services (DDS) program. Below you will find Information about the program along with a DDS application. Please review all of the information before submitting an application. If, after reviewing the information, you believe you may be eligible for the Donated Dental Services program, please submit an application for consideration.

If you submit an application, please make sure it is complete. Every line should be filled out. If a question does not apply to you, please write N/A. Please make sure you sign the application. We must have a signed copy. You can email, fax, or mail the application back.

*PLEASE NOTE, WE ARE NOT ABLE TO ACCEPT PHOTOS OF YOUR APPLICATION. If you do not have the ability to scan the document in order to email, please place it in the mail. We recommend that you keep a copy for your records.

If you have questions, please feel free to contact Penny Jordan:

Phone: (804)523-2182

Email: pjordan@vadental.org

We are happy to mail you an application packet if that is more convenient for you. If so, please email Penny your mailing address.

Please note, because of the long waitlist in the following areas, we are not accepting applications in these counties until September 1, 2022.

Northern Virginia

Alexandria
Arlington
Culpeper
Fairfax
Falls Church
Fauquier
Greene
Loudoun
Madison
Manassas
Orange
Prince William

Tidewater

Accomack
Chesapeake
Isle of Wright
Norfolk
Northampton
Poquoson
Portsmouth
Suffolk
Surry
Virginia Beach



Dear Applicant,

The Donated Dental Services program provides free dental care to eligible applicants. Volunteer dentists, specialists, and dental laboratories offer comprehensive dental treatment to eligible applicants. DDS volunteers give their time and use their resources to provide the services to you.

Please carefully review the following program requirements.

If you have already been through our program, please do not apply again. The DDS program is a once-in-a-lifetime program.

Core Eligibility Requirements: To be eligible for the DDS program, you must meet **ONE** of the following three requirements:

- 62 years of age or older, or
- Permanently disabled and receiving SSI or SSDI, or
- Medically Compromised
 - Medically Compromised individuals have a severe medical condition that is being exacerbated due to their oral health and, as a result, pose a significant risk of increased morbidity.

In addition, you must meet **ALL** of the following criteria:

- You have not received services through the DDS program in the past,
- Your **Household** income is no higher than 150% of the Federal Poverty Guidelines
- You have reliable transportation
- You require comprehensive dental care (more than just routine cleaning, a filling or two)
- The dental care you need is a service provided through the DDS program. Please note, implants, sedation, and other types of extensive oral surgery are not covered under the DDS program. Some cases are too complex for the DDS program.

Required Documentation – Income Verification:

Please return the completed application with a copy of **ONE** of the following required documents.

- A copy of your most recent federal tax return (if applicable),
- A copy of your Disability Benefits Statement confirming your disability and your monthly income (if applicable) or, A copy of your Social Security Benefits Statement documenting your monthly income (if applicable).

After reviewing your application, we may determine that additional documentation 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.

WAITLIST: Unfortunately, due to the overwhelming number of individuals needing dental care in Virginia, the DDS program must maintain a waitlist. If you are eligible for our program, you will be placed on the waiting list. We are not able to provide you with an estimated wait time. Your time



on the waitlist will depend on several factors, such as the part of the state you live in, how many volunteers are currently working with patients, and how long the treatment plans are for active patients.

APPLICATION PROCESS:

Step One

Fill out the entire application the best that you can. Do not leave any sections blank. If a question does not apply to you, write N/A. If you are disabled, please include proof of disability (e.g., SS Award Letter) with your application.

Step Two

Once we receive your completed and signed application, we will determine if you are eligible for the DDS program, and we will contact you. It generally takes 35 to 40 days to process new applications. If you are eligible, we will let you know the next steps. If you are not eligible, we will explain why and provide you with other resources that may help you.

If you are eligible, you will be placed on the waiting list in the order that your application was received. ***Depending on where you live, the wait can be several months, or the wait can be over a year.**

Step Three

When your application comes to the top of the waitlist, 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 accept your case, we will provide you with the information you need to get started.

Final acceptance into the program will be made after your first appointment with the dentist. Once we receive your treatment plan, we will be able to determine if the care you need is a service provided under the Donated Dental Program. Additionally, you may initially qualify for the program but may become ineligible later if your circumstances change while you are on the waitlist. Once you are next on the waiting list, we may require additional documentation to confirm that you are still eligible for the program.

We are sorry you are having a dental problem. We hope the Donated Dental Services (DDS) program may be of some help.

You will need to mail, scan and email, or fax your complete and SIGNED application by:

- Mail: DDS Program, 3460 Mayland Drive, Suite 110, Richmond, VA 23233
- Fax: (804) 523-1880
- Email: PJordan@vadental.org

***Please note – we cannot accept photos of your application via email. If you cannot scan your application, please mail it to our office. Please keep a copy for your records.**

Penny J. Jordan, Donated Dental Services (DDS) Program Manager
Address: 3460 Mayland Court, Suite 110, Richmond, VA 23233
Phone: (804) 523.2182
Email: [*pjordan@vadental.org](mailto:pjordan@vadental.org)

Donated Dental Services (DDS)

Frequently Asked Questions and Answers

1. I have a dental emergency. Can you help? We do not offer emergency treatment. There is a waiting list for treatment, and it can often take 4 to 8 weeks to find a dentist to accept your case when you are next on the waitlist. Additionally, the dentists are volunteers who fit you into their busy schedules, and they cannot handle emergency cases that require immediate attention. If you are in pain and need emergency care, call (804) 523-2182 or email pjordan@youraaa.org. We can send you a list of agencies in your area that may be able to help you with your emergency. When you no longer need immediate care, you may be eligible for the DDS program.

2. What kind of dental care can I get through the DDS program? The DDS program provides comprehensive, non-emergency dental care based on the treatment plan provided by your volunteer dentist. If you disagree with or request a different treatment plan, you are no longer eligible for the DDS program.

Routine dental care such as cleanings and one or two fillings are not covered. Since the services and materials are donated (dentures, crowns, etc.), 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 is what we are working towards.

The DDS program does not cover implants, sedation, and certain types of extensive oral surgery. Some cases are too complex for the DDS program.

3. How will I know if you received my application? Applications are processed within 35 days of receipt. If you have not received a phone call or email from the DDS coordinator after 35 days, please call (804) 523-2182 to check on the status.

4. How can I find out where I am on the waitlist or how long my wait is? Unfortunately, we cannot answer questions about wait times and where you are on the waitlist. Many factors affect the wait time, such as the availability of volunteer dentists and the length of time it takes for active patients to complete their treatment plans.

5. How far will I have to travel? We make every effort to place you with a dentist near you. We never place you with a dentist that is more than 30 miles away unless we absolutely must due to a lack of dental resources in your area.

6. Are the dentists paid? The dentist and oral surgeons are not paid. They are volunteering their time to provide you with free dental care. We ask that you be respectful and gracious when working with your volunteer dentists. In addition, any material needed for things such as dentures and crowns is donated by dental labs.



Foundation
VIRGINIA DENTAL ASSOCIATION

**Donated Dental
Services (DDS)**



Donated Dental Services (DDS)

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

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

Race is not considered when determining your eligibility for the DDS program. We collect this information for reporting purposes only. Many of our funders request this information.

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: _____

Number of people living in your household: _____

Name of each person	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For office use only: App #: _____

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

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

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 will not be complete until we have proof of income documentation)

<u>Program</u>	<u>Monthly amount</u>	<u>Date began</u>
SSDI/SSI:	_____	_____
SOCIAL SECURITY:	_____	_____
SNAP:	_____	_____
TANF:	_____	_____
UNEMPLOYMENT:	_____	_____
OTHER:	_____	_____

OTHER HOUSEHOLD MEMBERS INCOMES:

<u>Name</u>	<u>Gross Income</u>	<u>Name</u>	<u>Gross Income</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____ SAVINGS \$ _____ INVESTMENTS \$ _____

MONTHLY EXPENSES: Housing: _____ Phone: _____ Utilities: _____

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

Bus/other Transportation: _____ Health Insurance: _____ Life/Burial Insurance: _____

Medication: _____ Other Medical costs: _____ Other: _____

TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ _____

TRANSPORTATION

How will you get to your dental appointments? _____

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

Do you own a car? _____ Yes _____ No Can you drive to dental appointments? _____

INSURANCE

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

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: _____

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 conditions. 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 the 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/Virginia Dental Association Foundation to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS program to and hold the Virginia Dental Association Foundation 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 the Virginia Dental Association Foundation, 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. I understand that if I do not agree with the volunteer dentist’s treatment plan, I am no longer eligible for the DDS program.

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 Virginia Dental Association Foundation 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: _____

Donated Dental Services (DDS)

Medically Compromised Questionnaire

If you believe you are eligible for the DDS Program because you are Medically Compromised, please answer the questions below. If you answer “yes” to any of the questions, you will need to have your treating physician complete the **Medical Triage Form** included in this packet. The Medical Triage Form will need to be included with your completed application.

1. Do you have an artificial heart valve and/or stent? Yes _____ No _____
2. Do you receive treatment for heart disease? Yes _____ No _____
3. Are you currently on dialysis? Yes _____ No _____
4. Do you have a current dental infection? Yes _____ No _____
5. Have you ever had an organ transplant? Yes _____ No _____
6. Are you currently being treated for cancer? Yes _____ No _____
7. Do you have osteoporosis? Yes _____ No _____
8. Do you have rheumatoid arthritis? Yes _____ No _____
9. Do you have Lupus? Yes _____ No _____
10. Do you have Multiple Sclerosis? Yes _____ No _____
11. Do you take Clozaril? Yes _____ No _____
12. Do you have Crohn’s disease? Yes _____ No _____
13. Do you have an artificial joint or other orthopedic hardware? Yes _____ No _____
14. Have you taken any of the following medications: Boniva, Prolia, Fosamax, Reclast, Actonel, Interferon?
Yes _____ No _____
15. Do you have a Major Disability or Health Condition not listed that would be exacerbated by neglected dental needs? Yes _____ No _____ *if you answered yes, please provide details below

Other Major Disabilities or Health Conditions

Please provide details about any major disability or health conditions you have that are not listed above. Include the date you were diagnosed, symptoms, treatments, etc. Use the back of the page, in necessary.

Donated Dental Services (DDS) - Medical Triage Form To Be Completed by Physician

DDS is dedicated to helping individuals with disabilities, older adults, and the medically fragile/compromised. We need your help to prioritize the dental needs of your patient.

Patient Name _____

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 that apply

- ___ 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 risking aspiration because of missing teeth & impaired mastication
 - *Dysphagia is related to which disease? _____
- ___ 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

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: _____

Physician Address: _____

Physician Phone: _____



**Donated Dental
Services (DDS)**



Foundation
VIRGINIA DENTAL ASSOCIATION

Donated Dental Services (DDS)

PHOTO AND INFORMATION CONSENT FORM

COMPLETING THIS FORM IS OPTIONAL.

I authorize the Virginia Dental Association Foundation to use my name, information, statements, or photographs for public relations purposes and 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 organization's programs and encourage involvement from dental professionals and funders. I also agree that no material needs to be submitted to me for further approval, and I give the organization the right to copyright such material if necessary.

I understand that providing consent is entirely at my discretion.

I understand that my eligibility and the services I receive through the Donated Dental Services program will not be affected in any way if I choose not to provide my consent.

Signature: _____ Date: _____

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