



# Donated Dental Services (DDS)

RETURN APPLICATION TO:  
Donated Dental Services (DDS)  
4701 Cox Road, Ste. 111  
Glen Allen, VA 23060  
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 \_\_\_\_\_)

**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:**

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**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?

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

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Use this space to elaborate on any information not sufficiently explained in other areas:

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**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: \_\_\_\_\_