

MISSISSIPPI DONATED DENTAL SERVICES (DDS)

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 Mississippi have volunteered to provide comprehensive dental care at no charge to people of all ages who, because of a serious disability, advanced age, or medical problems, lack adequate income to pay for needed dental care. There are no rigid financial eligibility requirements.

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 review, a coordinator will call to obtain additional information (those who don't qualify will be informed),

Step Three the program 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 examination when the specific treatment needs are established.

Upon receipt, your application will be placed on our waiting list. Please be patient; due to program limitations, we are not able to process each application as soon as it is received. The 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,

Carolyn Talley
DDS Referral Coordinator

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

MISSISSIPPI DONATED DENTAL SERVICES
P.O. Box 16876
JACKSON, MS 39211-6876
(601) 368-9823
(800) 366-3640

DATE OF APPLICATION: _____
HAVE YOU RECEIVED SERVICES THROUGH
THE DDS PROGRAM BEFORE? ___ YES ___ NO

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: _____

<u>NAME OF EACH PERSON</u>	<u>AGE</u>	<u>RELATIONSHIP TO YOU</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____

SPOUSE'S MONTHLY WAGES: \$ _____

IF SPOUSE IS UNEMPLOYED, WHY? _____

PUBLIC ASSISTANCE:

PROGRAM	MONTHLY AMOUNT	HOW LONG HAVE YOU RECEIVED BENEFITS?
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SSI: _____

SOCIAL SECURITY DISABILITY: _____

AFDC: _____

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 INCL. FOOD STAMPS): \$ _____

GAS/ELECTRICITY: \$ _____ WATER/SEWER: \$ _____ CAR PAYMENT: \$ _____

CAR INSURANCE: \$ _____ GAS/CAR EXP: \$ _____ HEALTH INSURANCE: \$ _____

LIFE/BURIAL INS.: \$ _____ MEDICATIONS: \$ _____ MEDICAL COSTS: \$ _____

OTHER: _____

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, service 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 CASEWORKER: _____

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 permission for the referral coordinator to share pertinent information, about my eligibility, with one or more volunteer dentist 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 for 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 that 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 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 the Foundation 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 Foundation 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: _____