Elder Dental Program

10 Emory St.
Attleboro, MA 02703

781.769.3710
Fax 508-222-5871

Serving Attleboro, Canton, Dedham, Foxboro, Mansfield, Medfield, Millis, Norfolk, North Attleboro, Norton, Norwood, Plainville, Rehoboth, Seekonk, Sharon, Walpole, Westwood and Wrentham

Application for participation in the Elder Dental Program

This form will be used to determine if you are eligible for the Elder Dental Program. The program does not provide free care—it connects you with a dentist who has agreed to charge you special, reduced fees. These fees have been set by the program and are tied to your income level.

Applicant information

Name:

Phone Number:

Street Address:

Town: State: Zip Code:

Date of Birth:

Gender:

Marital status: ☐ Single/Divorced/Widowed ☐ Married

How did you hear about this program?

Are you on MassHealth? ☐ Yes ☐ No

(If you are, you can still participate in the Elder Dental Program, but you should know that MassHealth is does pay for a limited number of dental procedures for adults. To learn more, call MassHealth at 1-800-841-2900.)

Do you currently have a dentist? ☐ Yes ☐ No

If yes, please list dentist's name and town _____

Are you able to walk up stairs? ☐ Yes ☐ No

Do you have transportation to get to an appointment? ☐ Yes ☐ No

Oral health questions

1. Do you wear dentures? ☐ Yes ☐ No

2. When was your last cleaning?

3. Is anything hurting you now? ☐ Yes ☐ No
   If yes, explain:

4. Do you have any visible swelling in your mouth? ☐ Yes ☐ No
   If yes, explain:

5. Do you have any bleeding in your mouth or gums? ☐ Yes ☐ No
   If yes, explain:

6. Are any of your teeth loose? ☐ Yes ☐ No
   If yes, explain:

7. Do you have anything you'd specifically like a dentist to look at? ☐ Yes ☐ No
   If yes, explain:

8. Do you need pre-medication of antibiotics before dental work? ☐ Yes ☐ No

Financial information

This section helps us figure out if you are eligible for the program. **You must include documentation regarding your Social Security income and a copy of your most recently filed federal tax return.**

Income

Please complete this section about other income (**before** taxes and deductions).
*** * * If you are married, include your spouse's income.**

Type of income	Amount received per year	Comments
Social Security	$	
Railroad Retirement	$	
Veterans' Benefits	$	
Retirement Funds	$	
Wages	$	
Pensions	$	
Alimony	$	
Other Please specify:	$	

Resources

Resources usually include anything that can be turned into cash within 20 days.

Type of resource	Value	Comments
Checking account	$	
Savings account	$	
Certificates of Deposit (CDs)	$	
IRA	$	
Stocks	$	
Other	$	

Guidelines for Income Documentation:

- ☐ Please do not send original documents, only photocopies.
- ☐ Please provide a copy of your most recently filed federal tax return.
- ☐ Please provide **one** of the following documents to verify your Social Security Income
    - Annual Benefit Statement (SSA -1099 form)
    - Annual award letter from the Social Security Administration
    - A benefit verification letter from the Social Security Administration detailing income received within the past 12 months.
- ☐ If you do not have one of these documents, you may request a benefit verification letter by calling 1-800-772-1213, 7a.m. -7p.m., Monday –Friday, or by contacting your local Social Security Administration Office.
- ☐ Additional documents may be requested to verify resources.

Assignment of Rights

Please read this section carefully and sign at the bottom.

I realize that the dental care offered by dentists in the Elder Dental Program includes diagnosis, fillings, cleanings, and other basic procedures. I will be referred to dental schools or clinics for dentures and other similar restorative work. I understand the Elder Dental Program relies on grant funding and volunteers and is only able to accommodate patients based on available resources.

I understand that I have certain rights:

- I understand that I have the right to be treated with respect.
- I understand that my financial information will be kept confidential.
- I understand that my dental and medical information will be kept confidential.
- I understand that I will be told how much I should expect to pay before my dental appointments.

I understand that I have certain responsibilities:

- I agree to keep appointments with my dentist. **If I am unable to keep an appointment, I will reschedule with 48 hours' notice.**
- I agree to follow the plan of care and instructions developed and agreed to by myself and my dentist, recognizing that if I choose not to, I could experience undesirable health outcomes and probable discharge from the Elder Dental Program.
- I agree to pay my dentist at the time of the appointment.
- I agree to call the program manager immediately if I have a concern with or question about anything that happens at my dentist's office.

All information in this application is true to the best of my knowledge. I agree to provide additional documentation upon request.

_____ _____

Signature of Applicant Date

Mail completed application to:
Elder Dental Program
Community VNA
10 Emory St
Attleboro, MA 0703
Fax: 508-222-5871