480-850-1474
866-340-4337

Donated Dental Services Program

3193 N. Drinkwater Blvd.
Scottsdale, AZ 85251
azdentalfoundation.org

Thank you for 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 in Arizona have volunteered to provide comprehensive dental care at no charge individuals who are elderly (65+), have a special need (SSDI), or are medically compromised (i.e., transplant wait lists), and lack adequate income to pay for the needed dental care or have no dental insurance.

COST: There is generally no cost to qualifying individuals. On occasion, individuals in a position to pay for part of their care are encouraged to do so, especially when laboratory work or hospitalization is involved.

EXPECTATIONS: Understand that we do not offer "smile makeovers". This program is designed to restore your teeth to acceptable function and design and may be limited in the scope of care. We do not offer implants or cover hospitalization.

APPLICATION PROCEDURES:

Step One Complete, sign, and return the enclosed application,

Step Two When your application comes up for review, a referral coordinator will call to obtain additional information (those who don't qualify will be told so during the call),

Step Three The referral 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 clinical examination when the specific treatment needs are established.

Because of the extensive screening process, please **understand that this program cannot respond to emergency requests.** Also, because of the overwhelming demand for free dental services we are not able to process each applicant immediately. Upon receipt, your application will be placed on our waiting list – **waiting lists in all counties exceed two years.**

Be patient, the referral coordinator will contact you when your application comes up for review. However, we recommend that you continue to seek treatment through local resources while you are on the waiting lists – specifically we recommend using the hygiene schools to keep any oral disease under control.

If you feel your case is urgent or you do not fit our criteria, refer to the enclosed clinic referral list or log onto www.findadentist4.me and select the criteria specific to your needs (i.e., senior discounts).

We are sorry you are experiencing a dental problem and we hope the Donated Dental Services (DDS) program may be a source of some assistance.

Sincerely,
DDS Program Coordinator
480-850-1474/866-340-4337 rvsd.3/16

PLEASE KEEP THIS COVER LETTER FOR YOUR FUTURE REFERENCE.

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

DONATED DENTAL SERVICES
3193 N DRINKWATER BLVD.
SCOTTSDALE, AZ 85251
(480) 850-1474 / (866) 340-4337

DATE OF APPLICATION:________________
HAVE YOU APPLIED BEFORE?____________

APPLICANT

NAME:____ PHONE:____________________________

ADDRESS:____ PLEASE CIRCLE: MALE FEMALE

CITY, STATE, ZIP:____ COUNTY:___________________________

DATE OF BIRTH:____________________ AGE:_________ SERVED IN THE U.S. MILITARY:_____________________

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:_________

NAME OF EACH PERSON	AGE	RELATIONSHIP TO YOU

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?________________________________

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 TRAVEL 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.

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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 PERSON 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 ARIZONA DENTAL FOUNDATION PERMISSION TO RELEASE INFORMATION ABOUT MY MEDICAL CONDITION AND HOLD ADF HARMLESS FOR DOING SO.
I REALIZE THAT AN 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 ARIZONA DENTAL FOUNDATION, 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 ADF, 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 THE IMPORTANCE OF KEEPING ALL SCHEDULED APPOINTMENTS. FAILURE TO DO SO, WITHOUT AT LEAST A 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:______________________________ DATE:_______
(IF NECESSARY)
SIGNATURE OF PERSON REFERRING:______________________________ DATE:_______
(IF APPLICABLE)

OPTIONAL PHOTO AND INFORMATION CONSENT FORM

I GIVE PERMISSION TO THE ARIZONA DENTAL FOUNDATION 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, WEBSITES, SOCIAL MEDIA, MEDIA, ARTICLES, ADVERTISEMENTS, OR OTHER MARKETING MATERIALS THAT PROMOTE THE PROGRAMS OF THE ADF 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 ADF 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 THE DONATED DENTAL SERVICES PROGRAM.

SIGNATURE OF CLIENT:______________________________ DATE:_______

SIGNATURE OF CLIENT'S GUARDIAN:______________________________ DATE:_______
(IF NECESSARY)