Dear Applicant:

In response to your request for more information regarding how to apply for donated dental care, we are pleased to provide the following information and application for the Donated Dental Services Program (DDS), a program of Dental Lifeline Network·Seattle.

ELIGIBILITY:

Dentists in Seattle have volunteered to provide comprehensive dental care at no charge to people of all ages who are permanently disabled, elderly or medically fragile and lack adequate income to pay for needed dental care.

COST:

Qualifying individuals generally pay nothing, but occasionally, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is necessary.

DENTAL BENEFITS:

If dental insurance and/or Medicaid cover any portion of your dental problems, you will be asked to exhaust this resource.

APPLICATION PROCESS:

Step One
Complete entire application. Page 4 of the application provides consent for the Program Coordinator to obtain and share information about you, and Page 5 of the application provides consent for your physician to release medical information. Please return the application and both consent forms by mail, fax, or online as directed. Keep this page for your records.

Step Two
When your application is received and you appear to be eligible for DDS, your application will be placed on a waitlist in the order it was received. If you are not eligible, a letter of denial will be sent to you. Depending upon the area you live in, the wait will be several months or can be over a year. Please also be aware that we cannot return phone calls about where you are on the waiting list due to the volume of calls we receive and trying to help people through the program as quickly as possible.

Step Three
When your application comes to the top of the waitlist, DDS will contact you to tentatively determine eligibility. If a volunteer dentist agrees to evaluate your oral health, you will be given the information to schedule a consultation. Final acceptance into the program will be made only after the consultation and when the specific treatment needs are established by a volunteer dentist.

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

Sincerely,

Donated Dental Services (DDS) Program Coordinator
APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Donated Dental Services (DDS)
P.O. Box 2641
Vashon, WA 98070

Date of application: __________________________

APPLICANT INFORMATION

Name: __________________________ Phone: (____) __________________________ (home)
Address: __________________________ Phone: (____) __________________________ (cell)
City: __________________________ State: ______ Zip Code: ______ County: ______
Email Address: __________________

Date of birth: ________________ Age: ______ Male: □ Female: □ Military Veteran: □
Marital status: Single □ Married □ Divorced □ Widowed □ Separated □
Contact Person Name (relative, friend, etc.): __________________
Phone: (____) __________________________ Relationship to you: ______________________

Have you received services through the DDS program before? Yes □ No □
If yes, in which state? __________________________
How did you hear about the DDS program? __________________________

MEDICAL INFORMATION

Do you have an artificial heart valve and/or stent? Yes □ No □ Do you have osteoporosis? Yes □ No □
Do you receive treatment for heart problems? Yes □ No □ Do you have rheumatoid arthritis? Yes □ No □
Are you currently on dialysis? Yes □ No □ Do you have Lupus? Yes □ No □
Do you have Crohn’s disease? Yes □ No □ Do you have Multiple Sclerosis? Yes □ No □
Have you ever had an organ transplant? Yes □ No □ Do you take Clozaril? Yes □ No □
Are you currently being treated for cancer? Yes □ No □
Do you have an artificial joint or other orthopedic hardware? Yes □ No □
Have you taken any of the following medications; Boniva, Prolia, Fosamax, Reclast, Actonel, Interferon? Yes □ No □
Has your physician advised you that you need dental care immediately due to a medical condition? Yes □ No □

Major Disabilities or Health Problems (if your health problem is listed above please explain all in as much detail as possible, also include health problems not listed above):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Primary Physician's name: __________________________
Phone: (____) __________________________ Fax: (____) __________________________

Do you use a: Wheelchair: □ Cane: □ Walker: □ Scooter: □
Do you require wheelchair access? Yes: □ No: □
DENTAL INFORMATION
Briefly describe your dental problems: __________________________________________

How many natural teeth do you have remaining? # of Upper Teeth: _____ # of Lower Teeth: ______

Name of last dentist: __________________________________________ Phone: (_____) __________________

Approximate date of last dental visit: __________________________________________

How will you get to dental appointments? __________________________________________

Please list other cities or how far you are willing to travel in order to get dental treatment: ____________________________

REFERRING AGENCY or AGENCY THROUGH WHICH YOU RECEIVE SERVICES
Agency name: __________________________________________

Name of caseworker: __________________________________________ Phone: (_____) __________________

Address: __________________________________________ Fax: (_____) __________________

City: __________________________ State: ________ Zip: __________

HOUSEHOLD FINANCIAL INFORMATION
Number of people in your household: ______

<table>
<thead>
<tr>
<th>Name of each person in the household</th>
<th>Age</th>
<th>Relationship to you</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

MONTHLY HOUSEHOLD INCOME:
Are you able to work? Yes: ☐ No: ☐

If no, please explain why: __________________________________________

If you are employed, place of employment: __________________________________________

Your monthly employment income: $________________________

Is your spouse/significant other employed? Yes: ☐ No: ☐

If no, please explain why: __________________________________________

If they are employed, Place of employment: __________________________________________

Spouse's/significant other’s monthly employment income: $________________________

FINANCIAL ASSISTANCE: Monthly amount: Year benefit began:
SSI or SSDI Payments: $________________________
Social Security (retirement): $________________________
Unemployment/Workers Compensation: $________________________
Temporary assistance to needy families (TANF): $________________________
Other Public Assistance: $________________________
Total Monthly Household Income: $________________________

If you are not receiving disability, have you ever applied? Yes: ☐ No: ☐
Total value of savings: $__________
Type of investments/assets: ________________________________

Total value of investments/assets: $__________

Do you receive Food Stamps?  Yes: ☐  No: ☐  Monthly amount: $__________

Do you receive Medicaid benefits?  Yes: ☐  No: ☐  Medicaid #: __________________

Do you receive Medicare benefits?  Yes: ☐  No: ☐

Do you have a Medicare Advantage Plan?  Yes: ☐  No: ☐

Do you have dental insurance?  Yes: ☐  No: ☐

MONTHLY HOUSEHOLD EXPENSES:

<table>
<thead>
<tr>
<th>Expense</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>$________</td>
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<tr>
<td>Food (not including Food Stamps)</td>
<td>$________</td>
</tr>
<tr>
<td>Cable/Internet</td>
<td>$________</td>
</tr>
<tr>
<td>Out of pocket health insurance</td>
<td>$________</td>
</tr>
<tr>
<td>Is there a car in the household? Yes: ☐  No: ☐</td>
<td></td>
</tr>
<tr>
<td>If yes, make: __________________</td>
<td>Model: __________________</td>
</tr>
<tr>
<td>Car payment</td>
<td>$________</td>
</tr>
</tbody>
</table>

Other Monthly Expenses: __________________________

Total Monthly Household Expenses: $__________

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: ____________________________

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 DDS Coordinator to obtain information from 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.

I understand 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 give permission for the DDS Coordinator to share information about me with one or more dentist volunteering in the DDS program.

In addition, I understand if my disability is AIDS or HIV related, I give the DDS Coordinator of Dental Lifeline Network-Seattle permission to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS program and hold Dental Lifeline Network-Seattle harmless for doing so. 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 by ______ or upon ________.

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 Dental Lifeline Network-Seattle, 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 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.

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 Dental Lifeline Network-Seattle has no responsibility to assist me in obtaining the services of an alternate dentist.

I understand the 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, medical, and financial status.

Signature of client: ____________________________ Date: ____________

Signature of client's guardian (if necessary): ____________________________ Date: ____________

Optional Photo and Information Consent Form

I give permission to Dental Lifeline Network-Seattle 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 organization 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 organization 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: ____________
Dear Applicant,

Please complete and sign this form so that we can obtain necessary information.

Dear Medical Provider: _____________________________________

________________________________________________________,

(Patient Name)

is seeking care through the Donated Dental Services program, a humanitarian initiative through which volunteer dentists and laboratories provide comprehensive care without charge for individuals with mental, physical, and/or medical disabilities.

To better understand the relative clinical circumstances and needs of applicants, we inquire about the possible medical necessity and urgency for dental treatment. We therefore request at your earliest convenience that you please complete and return this form via fax directly to Dental Lifeline Network at 303-534-5290. Please print clearly.

By signing below, the applicant acknowledges understanding of and grants consent for the requested health history information to be shared with Dental Lifeline Network.

Applicant Name __________________________________________

Address  __________________________________________

City, State, Zip  __________________________________________

Date of Birth  __________________________________________

Applicant Signature __________________________________________

Date   __________________________________________

If you have any questions please do not hesitate to call me.

Thank you,

Donated Dental Services (DDS) Coordinator

1-877-861-6028