Donated Dental Program Requirements

ELIGIBILITY: Dentists have volunteered to provide basic dental care at no charge to people of all ages who, because of a serious disability and lack of adequate income, are unable to pay for dental care. **ONE MUST RECEIVE SSI OR SSDI or be over the age of 60 and income must meet Federal Poverty Guidelines in the household to QUALIFY.**

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

APPLICATION PROCEDURES:

**Step One** Please complete, sign, and return the application. Be sure to answer every question.

**Step Two** Include proof of income for everyone in the household. This means a copy of your “award” letter or pay check stubs that indicating how much the total income is in the household per month.

***Applicants cannot be screened without this information.***

**Step Three** When your application comes up for review, the referral coordinator may call to obtain additional information (those who don't qualify will be told so during the call or through a letter).

**Step Four** The referral coordinator will share the information about a person tentatively accepted with a volunteer dentist, and schedule an appointment, if possible.

**Step Five** You will be notified, by mail, of the dentist's name, address, and phone number along with your appointment date and time.
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 referral coordinator will contact you when your appointment is made!

The DDP program does not provide lifetime dental care; the Dentists do not donate routine cleanings or examinations after the initial treatment plan is complete. Cleanings, partials, dentures and full mouth extractions are not provided by the DDP program.

We are sorry you are experiencing a dental problem and we hope the Donated Dental Program (DDP) may be a source of some help.

IMPORTANT NOTICE:

IF AT ANYTIME INAPPROPRIATE BEHAVIOR ON THE PART OF THE PATIENT THE CAREGIVER IS OBSERVED BY THE DENTAL STAFF, SERVICES CAN IMMEDIATELY BE TERMINATED AT THE DENTIST’S DISCRETION. THEN THE COORDINATOR WILL HAVE TO TERMINATE YOU FROM THE PROGRAM.

Sincerely,

Janeice Armes

Janeice Armes, CIRS
DDS Program Director
P. O. Box 52763 (70505)
1005 Jefferson St.
Lafayette, LA 70501
337-232-4357 – Office
337-232-1960 – Fax
janeice@232-help.org
Please complete the application and return it to DDS Program Director, P.O. Box 52763, Lafayette, LA 70505. Please fill in all of the blanks, answering questions as well as you can.

**Clearly print the following information.** When finished, please read the statement on the last page. Sign and date the application if you understand and agree with the general terms and conditions of the program. When appropriate, a parent or guardian should sign.

**Please make note of the following:**
- There is a waiting list for assistance through the DDS Program.
- The DDS Program **DOES NOT** provide lifetime dental care; the dentist **DO NOT** donates routine cleanings or examinations after the initial treatment is complete. Cleanings, partials, dentures and full mouth extractions are **NOT provided**.
- All dental work **is restricted to the schedule** set up by and mailed to you from 232-HELP/211 Donated Dental Program as directed by the Dentist providing the services.

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Name

Street Address

Mailing Address (if different from above)

City State Zip Code

Birth Date Age Gender

Ethnicity: African Amer. □ Native American □ Hispanic □ White □ Other □

Please note: You are not required to check ethnicity- the information is for record keeping purposes only.

Physician(s)'s Name(s) ______________________________ Telephone #________________________

Are you covered by any other insurance programs? Yes □ No □ Dental coverage

Please give the name of a family member, friend, case manager, etc. who can provide information regarding your case, serve as an emergency contact person, and if necessary, help with transportation or other problems which may arise.

Contact Person ______________________________ Telephone #________________________

Relationship ______________________________ If case manager, with what agency? ________________________

Please list your disability or health conditions you may have: ________________________________________

_____________________________________________________________________________________

If you are a dialysis patient, on which days do you have dialysis? *(For scheduling purposes)*

_____________________________________________________________________________________

__________________________________             ____________________________________

Name Telephone #

__________________________________             ____________________________________

Street Address Telephone #

__________________________________             ____________________________________

Mailing Address Social Security #

Medicaid #

Medicare #

__________________________________             ____________________________________

City State Zip Code Medicare #
Please list all medications you are presently taking:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Please list any allergies that you may have: ________________________________________________

Do you require wheelchair access? Yes ☐ No ☐
Do you walk with the assistance of a cane or walker? Yes ☐ No ☐
Do you smoke or use tobacco products? Yes ☐ No ☐

What is your dental problem? (Please be specific)

_______________________________________________________________________________________
_______________________________________________________________________________________

Do you feel you may need extractions? Yes ☐ No ☐
How many? One ☐ Two ☐ Three ☐ Four ☐ Five ☐

*Please note: The DDS Program DOES NOT provide assistance for full mouth extractions, dentures or partials.

Please name your last dentist__________________________ Telephone # __________________ Date of last dental visit______________________________

If approved for dental assistance, how will you get to your dental appointment?
Self ☐ Member ☐ City Bus/Cab ☐ Other ☐

Are you able to travel outside of your area if necessary? Yes ☐ No ☐

Please list ALL the members in your household, TOTAL income amount and source for each member of your household including yourself.*Include proof of income for everyone in the household. This means a copy of your “award” letter or pay check stubs indicating how much each household member earns per month. Application will not be processed without this information.

How many are in your household? _______

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*Continue on back if additional space is needed.
Do you receive Food Stamps?  Yes ☐   No ☐  If so, amount: $________________

Please list your major expenses:

Rent/Mortgage_________________________ $_________________________ (Amount per month)
Utilities_____________________________ $_________________________ (Amount per month)
Phone_______________________________ $_________________________ (Amount per month)
Other______________________________ $_________________________ (amount per month)

Please list any additional information that you may want to provide the dentists.
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
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_______________________________________________________________________________________
I understand that I will need to provide personal information that includes, but is not limited to, my medical, dental and financial condition.

I give my consent for the referral coordinator to obtain information, relevant to my eligibility for the Donated Dental Services (DDS) Program, from my physician, dentist, individuals who know me and/or governmental or private agencies workers (this includes Social Workers, Case Workers, etc.).

I give permission for the referral coordinator to share pertinent information about my eligibility with any of above mentioned persons or more volunteer dentists in the DDS program.

I realize that application to the DDS program does not ensure that I will be referred for an examination or that I will be accepted as a patient following an examination.

I understand that 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 DDS Program, 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 maintain me as a patient.

*PLEASE INITIAL: _____

I understand there is a waiting list for assistance through the DDS Program. The DDS Program **DOES NOT** provide lifetime dental care; the dentist **DO NOT** donates routine cleanings or examinations after the initial treatment is complete. **Cleanings, partials, dentures and full mouth extractions are NOT provided.** All dental work is restricted to the schedule set up by and mailed to you from 232-HELP/211 Donated Dental Program as directed by the Dentist providing the services. *PLEASE INITIAL: _____

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 by you is a full and accurate disclosure of my current physical, mental and financial status

Signature _____________________________
Date____________________