NEW YORK DONATED DENTAL SERVICES (DDS)

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-New York.

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

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

MEDICAID: If Medicaid covers any portion of your dental problems, you will be asked to exhaust this resource before utilizing Donated Dental Services (DDS). Please call your local Medicaid Office or Department of Social Services.

APPLICATION PROCEDURES:

Step One
Complete entire application, sign and date last page, and return the enclosed application by mail to the address on the first page of the application. Keep this page for your records.

Step Two
When we receive your application, and you appear to be eligible, your application will be placed on a waitlist in the order your application 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.

Step Three
When your application comes to the top of the waitlist, DDS will contact you to tentatively determine eligibility.

Step Four
If you have been tentatively determined eligible for the program, DDS will share your information with a volunteer dentist who will determine if she or he would like to see you for a consultation.

Step Five
If a volunteer dentist agrees to a consultation with you, a letter will be mailed to you with the volunteer dentist's name and phone number 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 the 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,

DDS Coordinator

Helping People With Disabilities or Who Are Elderly or Medically Fragile
APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

NEW YORK DONATED DENTAL SERVICES (DDS)
281 PARK AVENUE SOUTH
NEW YORK, NY 10010
(212) 598-9000
(866) 616-9001
(212) 598-9001 Fax

DATE OF APPLICATION: ________________________

APPLICANT INFORMATION

NAME: __________________________ PHONE: (___) ____________________ (HOME)
ADDRESS: __________________________ PHONE: (___) ____________________ (CELL)
CITY: ______________ STATE: _______ ZIP CODE: _______ COUNTY: ________
EMAIL ADDRESS: __________________________
DATE OF BIRTH: _______________ AGE: _______ MALE: ☐ FEMALE: ☐
MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐
Contact person (relative, friend, etc.)
NAME: __________________________ 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? __________________________
NUMBER OF PEOPLE IN YOUR HOUSEHOLD: __________

NAME OF EACH PERSON: AGE: RELATIONSHIP TO YOU:
______________________________ _______ __________________________
______________________________ _______ __________________________
______________________________ _______ __________________________
______________________________ _______ __________________________

MAJOR DISABILITIES OR HEALTH PROBLEMS (EXPLAIN ALL IN AS MUCH DETAIL AS POSSIBLE):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

PRIMARY PHYSICIAN’S NAME: __________________________ PHONE: (___) ____________________
DO YOU USE A: WHEELCHAIR: ☐ CANE: ☐ WALKER: ☐ SCOOTER: ☐
DO YOU REQUIRE WHEELCHAIR ACCESS? YES: ☐ NO: ☐

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**FINANCIAL INFORMATION**

**MONTHLY INCOME:**

ARE YOU ABLE TO WORK?  YES: □  NO: □  
IF NO PLEASE EXPLAIN:______________________________________________

IF YOU ARE EMPLOYED, PLACE OF EMPLOYMENT:__________________________

YOUR MONTHLY INCOME: $______________

IS YOUR SPOUSE/SIGNIFICANT OTHER EMPLOYED?  YES: □  NO: □  
PLACE OF EMPLOYMENT:_____________________________________________

SPOUSE'S/SIGNIFICANT OTHER’S MONTHLY INCOME: $______________

IF SPOUSE IS UNEMPLOYED, WHY? ___________________________________________________________________________

**PUBLIC ASSISTANCE:**

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>MONTHLY AMOUNT</th>
<th>YEAR BENEFIT BEGAN</th>
<th>APPLIED/DENIED?</th>
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<tbody>
<tr>
<td>SOCIAL SECURITY DISABILITY INSURANCE (SSDI)</td>
<td>$______________</td>
<td>______________</td>
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<tr>
<td>SUPPLEMENTAL SECURITY INCOME (SSI)</td>
<td>$______________</td>
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<tr>
<td>SOCIAL SECURITY (62 YEARS OR OLDER)</td>
<td>$______________</td>
<td>______________</td>
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<td>UNEMPLOYMENT/WORKERS COMPENSATION</td>
<td>$______________</td>
<td>______________</td>
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<tr>
<td>TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)</td>
<td>$______________</td>
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<td>OTHER</td>
<td>$______________</td>
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<tr>
<td>OTHER</td>
<td>$______________</td>
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</tbody>
</table>

**TOTAL MONTHLY HOUSEHOLD INCOME:** $______________

**TOTAL VALUE OF SAVINGS:**  $__________________________

**TOTAL VALUE OF INVESTMENTS:**  $__________________________

**TYPE OF INVESTMENTS:**

**FOOD STAMPS?**  YES: □  NO: □  MONTHLY AMOUNT: $__________________

**MONTHLY EXPENSES:**

<table>
<thead>
<tr>
<th>EXPENSE</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>HOUSING</td>
<td>$______</td>
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<tr>
<td>FOOD (NOT INCLUDING FOOD STAMPS)</td>
<td>$______</td>
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<tr>
<td>ELECTRIC/GAS</td>
<td>$______</td>
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<tr>
<td>WATER/SEWER</td>
<td>$______</td>
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<td>PHONE</td>
<td>$______</td>
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<td>CABLE</td>
<td>$______</td>
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<td>CAR PAYMENT</td>
<td>$______</td>
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<tr>
<td>CAR INSURANCE</td>
<td>$______</td>
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<tr>
<td>CAR EXPENSES/GAS</td>
<td>$______</td>
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<td>MEDICATIONS</td>
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<td>MEDICAL COSTS</td>
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<td>HEALTH INSURANCE</td>
<td>$______</td>
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<tr>
<td>LIFE/BURIAL INSURANCE</td>
<td>$______</td>
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<td>CREDIT CARD/LOAN PAYMENTS</td>
<td>$______</td>
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<tr>
<td>OTHER</td>
<td></td>
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<tr>
<td>TOTAL MONTHLY HOUSEHOLD EXPENSES</td>
<td>$______</td>
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</tbody>
</table>

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BRIEFLY DESCRIBE YOUR DENTAL PROBLEMS: ____________________________________________
                                                                                     ____________________________________________
                                                                                     ____________________________________________

HOW MANY NATURAL TEETH DO YOU HAVE REMAINING? # OF UPPER TEETH: _______ # OF LOWER TEETH: _______

NAME OF LAST DENTIST: ________________________________________ PHONE: (____) __________

DATE OF LAST DENTAL VISIT: ______________________________

DO YOU RECEIVE Medicaid benefits? YES: □ NO: □ Medicaid #: ____________________________

DO YOU RECEIVE Medicare benefits? YES: □ NO: □ Medicare #: ____________________________

DO YOU HAVE DENTAL INSURANCE? YES: □ NO: □

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:

_____________________________________________________________________________________

IS THERE A CAR IN THE HOUSEHOLD? YES: □ NO: □

IF YES, MAKE: ______________ MODEL: __________ YEAR OF CAR: __________

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: ______________________________________________________________

REFERRING AGENCY or AGENCY YOU RECEIVE SERVICES THROUGH:

AGENCY NAME: ____________________________________________________________

NAME OF CASEWORKER: __________________________________ PHONE: (____) __________

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 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, dentist, 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 volunteer dentist in the DDS program.

In addition, I understand that if my disability is AIDS or HIV related, I must sign a further “HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information” released by the New York Department of Health, so that the referral coordinator may legally disclose my AIDS or HIV-related information to the volunteer dentist who will perform services for me under the DDS program.

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·New York, 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 organization, 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 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·New York 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·New York 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: ____________