RETURN COMPLETE APPLICATION TO
Access Partnership
P.O. Box 41093, Norfolk, VA 23541
FAX: 877-231-0196

Eligibility

1. Elderly (Age 65 or Older) OR
2. Permanently disabled (Receiving SSI, or SSDI) OR
3. Being treated for a serious medical condition which requires dental care to improve the condition or treatment options (i.e. Transplants, Chemotherapy, Uncontrolled diabetes)
4. Household income must fall within 150% of federal poverty guidelines
5. Must require comprehensive dental care (more than a routine exam, cleaning, or dentures only*)
6. Must have reliable transportation

APPLICANT INFORMATION

Name: _____ **Phone:** _____

Address: _____

City, State, ZIP _____SS Number:_____ Veteran? _____

Date of Birth: ____/ ____/ _____ **Age**: _____ **Race**: _____ **Gender** (circle one) Male Female

Marital Status: Single Married Divorced Widowed Separated

REFERRING AGENCY—How did you hear about this program?

Agency Name: _____ Phone #: _____

Name of case manager or social worker: _____

Address: _____

E-mail _____ Fax#: _____

Should we contact your case manager/ social worker in regards to your application? ____Yes ____ No

Alternative Contact Person (relative, friend, etc):

Name: _____ Phone: _____

Relationship to you: _____

Number of people living in your household: _____

Name of each person Age Relationship to you

_____

_____

_____

_____

For office use only

Date Received ____/ ____/ _____ CS ____/ _____/ _____

Status _____ NLS ____/ _____/ _____

Area _____ Intake ____/ _____/ _____

INSURANCE

Do you have Medical Insurance? ____Yes ____No If yes, what? _____

Do you receive Medicaid? ____Yes ____ No If yes, list Medicaid # _____

Do you have Medicare? ____Yes ____No If yes, list Medicare #_____

Do you have dental insurance? ____Yes ____ No If yes, name of insurance? _____

Do you get Veteran's Benefits? ____Yes ____No If yes, type? _____

Have you ever used the Donated Dental Services Program before? ____Yes ____ No

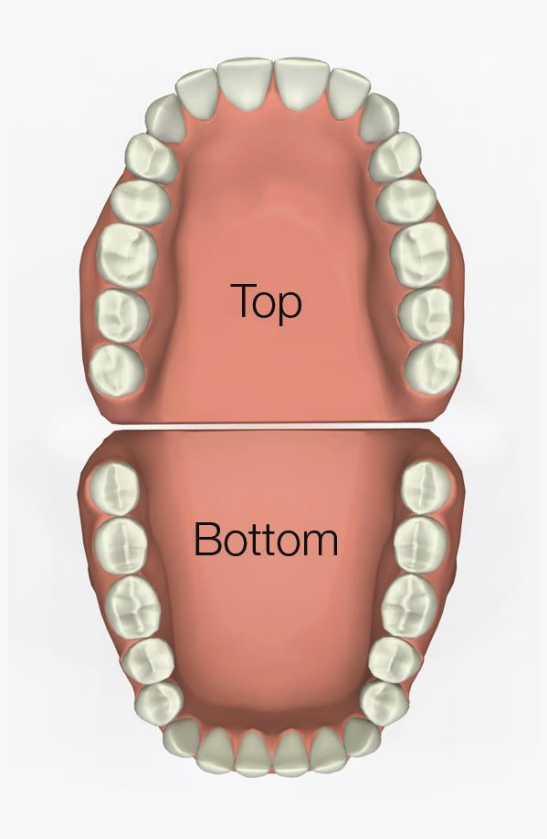
Are any family members able to help with cost of your dental treatment? ____Yes ____ No
If yes, please explain: _____

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: _____

Can you make payments toward your dental treatment? ____Yes ____ No

If yes, how much $_____

Using the picture, CIRCLE all teeth in need of dental work and place X through any teeth that are missing.



Additional information that helps explain your dental needs:

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH HISTORY QUESTIONNAIRE: **Information will be shared with prospective dentist/dental clinic.**

This information is current as of _____/ _____/ _____

What are your Major Disabilities or Health Problems (Explain in as much detail as possible)?

_____

DENTAL INFORMATION
Previous Dentist _____ Phone: _____

Date of last dental visit: _____/ _____/ _____ Services Performed _____

WHAT ARE YOUR DENTAL NEEDS?_____

_____

_____

How long have you had the above mentioned dental problems? _____

HEALTH INFORMATION: List all medication currently taking (include prescription medicine, over-the-counter meds, vitamins, inhalers)

_____

_____

ALLERGIES: List each allergy (including latex) & the reaction you have to each:_____

_____

_____

CIRCLE ALL HEALTH CONDITIONS THAT YOU HAVE:

Adrenal Disease	Bronchitis	Heart Disease	Peptic Ulcer Disease
Angina/MI	Cancer	Heart Murmur	Renal Disease
Arthritis	Chronic Cough	Hepatitis	Shortness of Breath
Asthma	Diabetes	HIV/AIDS	Steroid Use
Artificial Joints	Emphysema	Hypertension (HBP)	TB
Bleeding Disorders	Epilepsy/Convulsions	Muscular Diseases	Thyroid Disease

List Recent Surgeries (within 6 months): _____

Smoker? YES NO **Other Health Conditions?**_____

Are you pregnant/nursing or planning to become pregnant? YES NO

Do you require wheelchair access? YES NO
Doctor's Name (s): _____Telephone _____

FINANCIAL INFORMATION:

Income: Please include incomes for all eligible dependents who are a member of your household

Are you able to work? Part-Time ____Yes ____ No Full-Time ____Yes ____No

If no, please explain: _____

_____

Are you employed? ____Yes ____ No Place of Employment: _____

Your monthly wages: $_____

Is you spouse employed? ____Yes ____ No Place of Employment: _____

Spouse's monthly wages: $_____

If your spouse is unemployed , why? _____

PUBLIC ASSISTANCE:

Program	**Monthly Amount**	**When did you begin receiving this?**
SSI:	_____	_____
Social Security Disability:	_____	_____
AFDC:	_____	_____
Social Security:	_____	_____
Unemployment:	_____	_____
Other:	_____	_____
Food Stamps	_____	_____

Other Income

Name	Monthly Income	Relationship
_____	$_____	_____
_____	$_____	_____

TOTAL MONTHLY HOUSEHOLD INCOME $ _____

Total value of savings: $_____ Total value of investments $ _____

MONTHLY EXPENSES:

Housing: $_____ Phone $_____ Food (not including food stamps) $_____

Gas/Electric $ _____ Water/Sewer $ _____ Car Payments: $ _____ Car Insurance _____

Gas/Car Exp: $ _____ Health Ins $_____ Life/Burial Ins. $_____ Medications $_____

Other medical costs $_____ Other: _____

TOTAL MONTHLY HOUSEHOLD EXPENSES: $ _____

TRANSPORTATION

How will you get to dental appointments? _____

Do you own a car? YES NO If Yes, year and model of car: _____

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 project coordinator to obtain information relevant to my eligibility for the DDS program from my physicians, dentists, individuals who know me and/or government or private agencies.

I give permission for the project coordinator to share pertinent information, about my eligibility, with one or more volunteer dentists in the DDS program. If my disability is AIDS or HIV related, I give Access Partnership and the Virginia Dental Association Foundation (VDAF), which coordinates the DDS program, permission to release information about my medical condition and hold Access Partnership & VDAF harmless for doing so.

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 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 DDS, 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 obligatedto provide donated care in the future or to maintain me as a patient. I further understand that I am only eligible for services through the DDS program **one time**, and it is my responsibility to find follow-up dental care to maintain good oral health.

I understand the importance of keeping all scheduled appointments. Failure to do so (without at least 24 hours notice to the dentist) or the rescheduling of appointments, 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.

Note: I understand that any information concerning my case including any pictures or videos that I may appear in are the property of the DDS program (Access Partnership and VDAF) and may be used in newsletter, brochures, journals, grant proposals, and other promotional materials.

Signature of applicant: _____ Date: ____/____/_____

Signature of applicant's guardian: _____ Date: ____/____/_____