D-DENT, Inc. is a non-profit organization that coordinates the services of volunteer dentists.

D-DENT is not a dental clinic. Therefore, D-DENT is unable to accommodate dental emergency needs.

WHO QUALIFIES?

• An Elderly person who is low-income and uninsured. To be considered elderly, you must be 60 or older. PHOTO I.D., & PROOF OF INCOME ARE REQUIRED

• A Developmentally Disabled person who is low-income and uninsured. Although there are many reasons why a person may be considered disabled, D-DENT’s guidelines state that to qualify, you must have a “DEVELOPMENTAL” disability such as Mental Retardation, Cerebral Palsy, Down Syndrome, Spinal Bifida, Muscular Dystrophy, Epilepsy...etc. MEDICAL LETTER, PHOTO I.D., & PROOF OF INCOME ARE REQUIRED.

• A Veteran who is low-income and uninsured. A veteran who does not have a 100% service-connected disability, has no access to dental care through the V.A. PHOTO I.D., COPY OF DD-214, & PROOF OF INCOME ARE REQUIRED.

MAKE SURE TO FILL OUT BOTH FRONT AND BACKSIDE OF APPLICATION. APPLICATIONS WITH MISSING INFORMATION WILL NOT BE PROCESSED.
DO NOT RETURN THIS PAGE WITH YOUR APPLICATION
***KEEP THIS PAGE FOR YOUR RECORDS***

D-DENT, Inc. NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in the facility and will not be misused or disclosed by/to anyone outside of D-DENT and/or the volunteer dentist you will be assigned to. You may gain access to this information if you desire. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on February 1, 1986 and will remain effect. We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our office and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment and healthcare providers. For example:

TREATMENT We may use or disclose your health information to a physician, dentist, or healthcare provider who will be providing treatment to you through D-DENT.

HEALTHCARE OPERATIONS We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioner/dentist and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

YOUR AUTHORIZATION You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member calling on your behalf, referral to volunteer dentist or specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS We must disclose your health information to you as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment.

- D-DENT is a 501(c)3 non-profit organization. We are not a dental clinic.
- We manage dental professionals’ charitable efforts in private clinic settings. They are volunteers.
- This program is not for emergency dental needs.
- Application to the program does not guarantee acceptance into the program.
- If accepted, you will be placed on a waiting list.
- If denied, you will receive a denial letter explaining why you did not meet eligibility guidelines.
- Waiting period can be anywhere between 1 month to 5 years.
- D-DENT will only call you when it is your turn.
- It is your responsibility to call D-DENT to update your contact information whenever it changes.

D-DENT, Inc. (405) 424-8092 (800) 522-9510 www.d-dentok.org

DENT, Inc.
**Who referred you to D-DENT?**

Name: ____________________________
Street: ____________________________
Suite/Apt #: ______________________
City: __________________ State: _____ Zip: ___________
County: __________________________ P.O. Box: ___________

**MAIL COPY OF I.D.**

Provide 2 contact info in case we cannot get in touch with you:

1. Name __________________ Phone (_____) _____-______
Relation to you ________________ Mobile (_____) _____-______
E-mail __________________________

2. Name __________________ Phone (_____) _____-______
Relation to you ________________ Mobile (_____) _____-______
E-mail __________________________

**Dental Problems/Needs (Check all that apply)**

- Need teeth cleaned
- Need teeth removed
- Need partial denture
- Need full denture
- Need fillings
- Need root canal
- I have NO natural teeth

**Other dental work (specify below):**

**Do you have transportation to get to the dental clinic?** ________________

**How far can you drive to see a dentist?** ___________________________

**How long has it been since you saw a dentist?** ______________________

**How many teeth are left on top?** _____

**How many teeth are left on bottom?** _____

**Do you have dental insurance?** ______

**Are you over 60 years old?** _____

**Are you a veteran?** (yes or no) _____

**If so, PLEASE SEND COPY OF DD-214**

Do you have any other health problems such as heart condition, cancer, blood disorder, paralysis, etc.?

__________________________________________________

**History/Dental problem:**

__________________________________________________

**Access problem - Why have you not seen a dentist?**

__________________________________________________

**Do you have a disability for which you receive State benefits? (yes or no)**

**Are you a veteran? (yes or no)**

Do you have blood thinners? ______

Do you have artificial joints or pacemaker? ______

**Other Primary/Secondary Impairments** (Mail copy of Disability letter)

- Cerebral Palsy
- Epilepsy
- Autistic
- Paraplegia
- 100% Blind
- 100% Deaf
- Cystic Fibrosis
- M.S.
- Other DD

**Other Developmental Disability:**

**Who do you authorize for the release of information?**

- My Case Manager
- My Program Coordinator
- Relatives
- Other people: __________________________

**Additional Problems:**

________________________________________

**Additional Notes:**

________________________________________

**Who referred you to D-DENT?**

**Their Phone (____) _____-______**

**Do you have Soonercare or Medicaid?** ______

**If so, what is the number?** __________________________

**If we cannot get ahold of you by phone, may we contact you by e-mail?** If so, what is your e-mail address? __________________________

**Dental Problems/Needs (Check all that apply)**

- Need teeth cleaned
- Need teeth removed
- Need partial denture
- Need full denture
- Need fillings
- Need root canal
- I have NO natural teeth

**Other dental work (specify below):**

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__________________________________________________

**History/Dental problem:**

__________________________________________________

**Access problem - Why have you not seen a dentist?**

__________________________________________________

**Do you have a disability for which you receive State benefits? (yes or no)**

**Are you a veteran?** (yes or no) _____

If you need assistance with this form, please call D-DENT at 405-424-8092.

Mail form, copy of I.D. & proof of income to: D-DENT 3000 United Founders Blvd. #122, OKC, OK 73112.
INCOME EXPENSES (please list monthly expenses)

<table>
<thead>
<tr>
<th>Total household income</th>
<th>Number of people living at home (including yourself)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings account</td>
<td></td>
</tr>
<tr>
<td>Certificate of Deposit</td>
<td></td>
</tr>
<tr>
<td>Other income</td>
<td></td>
</tr>
<tr>
<td>Food Stamps</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rent/Mortgage</th>
<th>Phone/Cable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilities(Gas)</td>
<td>Food</td>
</tr>
<tr>
<td>Utilities(Electric)</td>
<td>Medication</td>
</tr>
<tr>
<td>Utilities(Water)</td>
<td>Med. Bills</td>
</tr>
</tbody>
</table>

If recipient of public assistance program, please list details:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Amount and Sources of Income in Household (Itemize):
________________________________________________________________________
________________________________________________________________________

PLEASE REMEMBER TO PROVIDE PROOF OF INCOME FOR EACH HOUSEHOLD MEMBER.

SEND COPY (NO ORIGINALS) OF: Valid I.D., Proof of Income, DD-214 (if applicable)

IF YOU HAVE NO INCOME, YOU MUST PROVIDE INFORMATION ABOUT WHO PAYS FOR YOUR EXPENSES.

PATIENT RESPONSIBILITIES GUIDELINES:

1. Get my own ride to each dental appointment.
2. Arrive on time or early (15 minutes before scheduled time)
3. Be kind, thankful, respectful and cooperative with the volunteer dentist and staff at all times.
4. I understand and agree that all appointments must be made by D-DENT staff and that I am responsible for calling D-DENT after each dental appointment to report appointment information.
5. I agree to NOT cancel or change any dental appointments unless I have called and received permission from D-DENT staff.
6. I understand and agree that if, at any time during my treatment, I behave inappropriately, discourteous or uncooperative, act or talk rude, I will be disqualified to receive dental care and I will be removed from the D-DENT program and cannot get more dental treatments.
7. I understand that ONE (1) NO SHOW appointment may disqualify me from receiving dental care through D-DENT.
8. I understand that D-DENT is a one-time pass through program. After the volunteer dental professionals have finished their treatment, my case will be considered COMPLETED and I will not be eligible for future dental treatment through D-DENT.
9. I understand and agree to follow directions of the dentists and staff to preserve and do my best to maintain my dental health, including the practice of regular dental hygiene procedures and care of prosthetic appliances as indicated.
10. I understand and agree that I can be dropped from the D-DENT program at any time if I do not follow the rules of this contract.
11. I understand that if I’m eligible, I will be placed on a WAITING LIST. The waiting period varies per case. It can be anywhere between 1 month to 5 years depending on the need, the area of residency, volunteers, and funding availability.

BY SIGNING THIS FORM YOU AGREE TO THE FOLLOWING STATEMENTS:

✓ I have read and understand the 11 patient responsibility guidelines listed above.
✓ I certify that I understand the questions on this form and the penalties for giving false statements or withholding information. Under the penalty of perjury, I certify that I have given true, accurate, and complete statements to the best of my knowledge, for each household member, including myself, for whom I am applying.
✓ I authorize D-DENT to share information about my application, dental needs and dental treatment with FUNDING SOURCES & D-DENT’s VOLUNTEER DENTISTS as well as those listed as contacts on this form.
✓ I authorize D-DENT to request information about my dental treatment, including x-rays, treatment plan, and treatment notes from volunteer's dental clinic.

SIGNATURE______________________________________________________  Today’s Date_________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

✓ I have received a copy of D-DENT’s notice of privacy practices.

Please Print Name____________________________________________ Date________________
Signature____________________________________________________

FOR D-DENT USE ONLY

Entered by_______ Reviewed _____________ Action: APPROVED  DENIED - Reason:________
File location__________________________________________

IF YOU NEED ASSISTANCE WITH THIS FORM, PLEASE CALL D-DENT AT 405-424-8092.
MAIL FORM, COPY OF I.D. & PROOF OF INCOME TO: D-DENT 3000 United Founders Blvd. #122, OKC, OK 73112.
REQUEST FOR DENTAL CARE THROUGH D-DENT
(Dentists for the Disabled and Elderly in Need of Treatment, Inc.)

NOTICE OF LEGAL IMMUNITY FOR VOLUNTEERS

ALL OF THE PERSONS THAT PROVIDE CARE AND SERVICES FOR D-DENT PARTICIPANTS ARE VOLUNTEERS.

VOLUNTEERS PROVIDING FREE SERVICES HAVE LEGAL IMMUNITY FROM LIABILITY IN CIVIL ACTIONS UNDER STATE AND FEDERAL LAWS FOR THE VOLUNTEER SERVICES, INCLUDING HEALTH CARE.

IF A COURT DECIDED THAT A VOLUNTEER IS ENTITLED TO THE PROTECTION UNDER THESE LAWS, YOU WOULD NOT BE ABLE TO RECOVER ANY MONEY FOR ANY DAMAGE OR BODILY INJURY, EVEN IF YOU FILE A LAWSUIT.

Last Name _________________________    First Name _______________________   Middle Initial____  DOB _________

REQUEST FOR DENTAL CARE

I hereby request to participate in and receive assistance that will be provided to me free of any cost or expense to me by D-DENT volunteers. This request is entirely voluntary on my part and is made with knowledge of the volunteer immunity described above, and with the understanding that in providing such assistance there are inherent risks of unintended accidental and/or negligent damages or bodily injury to me.

In exchange for receiving free services through D-DENT, I understand and accept that applicable laws may deny me the right to recover any monetary damages from D-DENT or any volunteer working through D-DENT, as a result of services provided by volunteers.

I hereby authorize D-DENT through its staff and volunteers to provide the requested care.

I hereby authorize D-DENT volunteer dentists, hygienists, dental assistants, to perform dental care on me or my dependent and to perform any first aid or emergency medical care that may become reasonably necessary for me in the course of such treatment.

This request for assistance from D-DENT may be considered by D-DENT and its volunteers to be a continuing authorization, and shall remain effective as evidence of my consent for D-DENT volunteers to provide the care I requested until I specifically notify D-DENT in writing that I am revoking and withdrawing my prior request, authorization, or consent.

By signing below I acknowledge that I have read the full contents of this notice and that I understand it.

IF YOU HAVE QUESTIONS, YOU SHOULD ASK ANY D-DENT STAFF OR VOLUNTEER TO PROVIDE FURTHER EXPLANATION TO YOU BEFORE YOU SIGN THIS REQUEST FOR ASSISTANCE. D-DENT (405) 424-8092 or (800) 522-9510

Applicant or Legal Representative Signature: _______________________________    Relationship to Participant (self, spouse, guardian, etc.): _______________________________

Signature ___________________________    Date ________________

Mail completed application with proof of income, copy of photo I.D. & other requested documents to:

D-DENT
3000 United Founders Blvd., Ste # 122
OKC, OK 73112

PLEASE READ THE PATIENT RESPONSIBILITY GUIDELINES
WE WILL NOT ACCEPT APPLICATIONS WITHOUT SIGNATURES OR REQUESTED DOCUMENTS

D-DENT, Inc.  (405) 424-8092  (800) 522-9510  www.d-dentok.org