Incomplete applications will cause processing delays. Questions? Call D-DENT at 405-424-8092

Who referred you to D-DENT? _____ Their phone ( ) -

Name: _____

Street Address: _____

Apartment # _____ City: _____

State: OK Zip: _____ County: _____

P.O. Box Address: _____

If we are unable to reach you by phone, can we E-mail you?

If YES, what is your E-mail: _____

Your SSN: _____

Home Phone: ( ) -

Cell Phone: ( ) -

Date of Birth: _____

Gender: _____

Race / Ethnicity: _____

Do you have Soonercare or Medicaid? *yes no*

If yes, provide # _____

PROVIDE COPY OF PHOTO I.D.

Provide two contacts in the event we are unable to reach you regarding the D-DENT application or dental appointment information:

Name: _____ Phone: ( ) - Name: _____ Phone: ( ) -

Relation to you: _____ Relation to you: _____

QUESTIONS TO HELP DETERMINE YOUR ORAL HEALTH NEEDS AND PLACEMENT THROUGH D-DENT

___I need my teeth cleaned.
___I need some fillings.
___I need SOME teeth removed.
___I need ALL teeth removed.
___I have NO teeth in my mouth

___I need a *PARTIAL* UPPER denture.
___I need a *PARTIAL* LOWER denture.
___I need a *FULL* UPPER denture.
___I need a *FULL* LOWER denture.
___I have SOME teeth in my mouth.

Do you have transportation to get to the dentist? *yes no*

How far can you drive to see a dentist? *Example 50 miles, anywhere*

_____

How long has it been since you last saw a dentist? *Example 2 yrs*

_____

How many teeth do you have remaining on the top? _____ (*include broken down teeth and roots under the gums*)*Example 10*

How many teeth do you have remaining on the bottom? _____ (*include broken down teeth and roots under the gums*)*Example 4*

If you have NO teeth left in your mouth (*not even root tips*), please tell us the approximate date of the last extractions: _____

MUST HEAL 6 MONTHS AFTER EXTRACTIONS DEFORE DENTURES ARE PROVIDED

QUESTIONS REGARDING YOUR OVERALL HEALTH TO DETERMINE BEST OPTIONS FOR DENTAL CARE

List major health conditions (*on oxygen, under cardiologist care, cancer care, paralysis, etc.*) _____

Do you smoke? *yes no* Do you take blood thinners? *yes no* Are you Diabetic? *yes no*

Do you have high blood pressure? *yes no* Do you have artificial joints? *yes no* Wheelchair bound? *yes no*

Are you 60 years or older? *yes no*

Are you a Veteran of the U.S. Forces? *yes no*

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

Do you have dental insurance? *yes no*

Do you have a Certificate of Degree of Indian Blood (CDIB)? *yes no*

IF VETERAN, PROVIDE COPY OF DD-214 OR CURRENT V.A. I.D.CARD

PROVIDE COPY OF DISABILITY LETTER

DEVE LOPMENTAL DISABILITY:

__ Cerebral Palsy
__ Paraplegia/Quadriplegic
__ Cystic Fibrosis
__ Low I.Q. (70 or lower)
__ Epilepsy
__ 100% Blind
__ M.S.
__ Other lD/DD: _____
__ Autism
__ 100% Deaf
__ Downs Syndrome

WHO CAN WE SPEAK WITH ABOUT YOUR D-DENT APPLICATION & CASE MANAGEMENT?

___My Case Manager
___My Program Coordinator
_X_D-DENT Volunteers/dental clinics
___Relatives or other people - please list names:
___My Spouse
___My contacts listed above

_____

QUESTIONS TO DETERMINE INCOME ELIGIBILITY

PROVIDE PROOF OF INCOME FOR ALL

How many people live with you? _____ (*include yourself when counting the total number of people living under the same roof*)

Examples of proof of income: Social Security determination letter, pay stub, 1st page of tax record, etc.

YOUR MONTHLY income

Social Security Income $_____
Social Security Disability $_____
Job Paycheck $_____
Pension/Retirement $_____
Food Stamps amount $_____

YOUR MONTHLY expenses

Rent-Mortgage $_____
Utility-GAS $_____
Utility-ELECTRIC $_____
Utility-WATER $_____
Phone-Cable $_____
Food/Groceries $_____
Prescriptions $_____
Medical Bills $_____
Home Ins. $_____
Health Ins. $_____
Car Ins. $_____
Life Ins. $_____
Dental Ins. $_____

For each additional person living with you, please list their source of income & amounts (*Pension, SSI, Retirement, Job, etc.*)

_____

List Public Assistance Received (*section 8 housing, food pantry, etc.*)

Read and sign backside of application.

_____

READ THE FOLLOWING STATEMENTS BEFORE SIGNING THIS FORM

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 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.

NOTICE OF LEGAL IMMUNITY FOR VOLUNTEERS

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

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 at all times with D-DENT staff, as well as the volunteer dentists and their staff.
4. ***I understand and agree that if at any time during my waiting period or during my treatment, I behave inappropriately, discourteous or uncooperative, act or talk rude to D-DENT staff and/or volunteer dentists and their staff, I will be disqualified to receive dental care. This means that I will be removed from the D-DENT program and I will not be eligible to receive and/or continue dental treatment through D-DENT.***
5. ***I understand that ONE (1) NO SHOW appointment MAY disqualify me from receiving dental care through D-DENT.***
6. 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.
7. I agree to NOT cancel or change any dental appointments unless I have called and received permission from D-DENT staff.
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 one (1) month to five (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 have read and understand the NOTICE OF LEGAL IMMUNITY FOR VOLUNTEERS listed above.
- ✓ I have read and understand the REQUEST FOR DENTAL CARE that I am making as listed above.
- ✓ I understand that I can request a copy of D-DENT's notice of privacy practices (HIPAA) by calling 405-424-8092.
- ✓ 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.

IF YOU HAVE QUESTIONS ABOUT ANY OF THE STATEMENTS ABOVE, CALL D-DENT AT (405) 424-8092 AND ASK THE STAFF TO PROVIDE FURTHER EXPLANATION, BEFORE YOU SIGN THIS REQUEST FOR ASSISTANCE.

Print Your Name_____ **Sign**_____ **Date**___ /____/____

APPLICATION MUST INCLUDE COPIES OF THE FOLLOWING DOCUMENTS:

Proof of Income (everyone) **Photo ID** (everyone) **DD-214** (if you are a veteran) **Disability Letter** (if you are disabled)

******APPLICATION DOES NOT GUARANTEE ACCEPTANCE******

Mail to: D-DENT 3000 UNITED FOUNDERS BLVD. #116, OKC, OK 73112

The D-DENT program is not for emergency dental needs. D-DENT is not a dental clinic. D-DENT is a 501(c)3 non-profit organization. We manage dental professionals' charitable efforts in private clinic settings. They are volunteers. If denied, you will receive a denial letter explaining why you did not meet eligibility guidelines. It is your responsibility to call D-DENT to update your contact information whenever it changes.