Michigan Donated Dental Services (DDS) Program Information & Application

***Please keep this page for your information and records.**

General Information

The Michigan Donated Dental Service Program (DDS) provides comprehensive dental treatment to individuals who have no other means of obtaining necessary dental treatment. Care is completely donated by volunteer dentists and dental labs. The program is administered by the Michigan Dental Association, funded by a grant through the State of Michigan Department of Health and Human Services, and operated as a licensee of Dental Lifeline Network.

Disclaimers

Submitting this application does not mean that you are accepted into the program. Once you have completed the application, telephone interview and any other necessary steps (this may include obtaining paperwork from other doctors who provide you with health and mental health care) you will be notified by the program whether or not you have been accepted for treatment.

By signing and submitting this application you understand that you are agreeing that the program can use the information contained in the application to evaluate whether or not you qualify to receive services from the program. You agree that the program may share your information with its volunteer dentists, their staff, dental laboratories and supply companies, as needed to obtain donated products and services for your treatment. The program will only share as much information as is necessary.

Eligibility Requirements

- **You must be elderly (65+), OR have a chronic health condition, OR have a permanent disability.** You may be asked to have your physician complete the attached form regarding your physical health. You may be required to provide proof of social security disability income. If you have a mental health condition, you may be required to be in treatment.
- **You must have household income under 200% of the federal poverty guidelines.** The approximate amount is $____ for a single household, $_____ for a two-person household, $_____ for a three-person household and $____ for a four-person household.
- **You must not have dental insurance.** If you have Medicare**,** Medicaid or a Medicaid spend-down, you will be required to use your benefit to have all covered services taken care of or prove that you were unable to access the care you need before you will be considered for the program. You must meet all other eligibility criteria.
- **You must not have previously received treatment through this program.**
- **You must need extensive dental care. We do not provide emergency or basic preventive treatment.**

How to Apply

- Complete **all** the information requested on the application form, including signing all releases and having your physician complete the health form if needed (see the bottom of page 3 to see if you need to complete this).
- We understand that some of the questions may not seem related to your dental needs, however, they help us understand your health and living situation and how we can best support you in reaching the best treatment outcome possible. They also help us match you with the volunteer dental office that can best meet your needs. Please rest assured your private information is secure and shared only as necessary.
- Sending an incomplete application can lead to a delay in processing.
- **Mail or fax your form to:**

  Michigan Donated Dental Services (DDS)
  3657 Okemos Rd., Suite 200
  Okemos, MI 48864
  Fax: 517-372-0008

What Happens Next?

- Please do not call to ask if we can speed up your application. If you need emergency care, please contact your local health department or visit your local emergency room. We cannot provide urgent or emergency care.
- Once we have received your completed application, we will mail you a postcard saying that we have received it.
- A caseworker will evaluate your application.
- If we determine you are not eligible for the program, you will receive a letter.
- If you are eligible or if we have more questions, a caseworker will call you to ask questions or set up a time when you can complete a phone interview.
- The phone interview will take approximately 20 minutes. The caseworker will ask questions about your teeth, physical health, finances, transportation, and other matters that may be needed to help us find you the right care provider and coordinate your care. Like the application, any information you provide to your caseworker will be kept confidential and shared only as needed to help you get the dental care needed.
- After your phone interview, the program will make a final determination on whether or not you are eligible. You will be notified either by a telephone call or letter and given additional instructions at that time.
- Please be patient. Our staff helps hundreds of people get donated care each year and works hard behind the scenes to help each one. It may take weeks or even months to complete each step of the process.

Michigan Donated Dental Service (DDS) Program Application

Date of Application: _____

Applicant Name: _____

Phone: _____(home) Phone: _____(cell)

Address: _____

City: _____State: Michigan Zip: _____ County: _____

Date of birth: _____ Age: _____ Gender: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Ethnicity: _____ Race: _____

Name of Person Completing/Helping Complete the Application:

_____

Relationship to Applicant: _____
Emergency Contact Person Name: _____
Phone: _____ Relationship to Applicant: _____

Have you received treatment through the DDS program before? ☐ Yes ☐ No
How did you hear about the DDS program? _____

Do you have dental insurance? ☐ Yes ☐ No
Name of insurance company or plan: _____

Do you have access to reliable transportation? ☐ Yes ☐ No
Do you have access to a reliable phone? ☐ Yes ☐ No

Name of last dentist: _____

Approximate date of last dental visit: _____
Reason for visit and treatment received: _____
Please count your existing natural teeth: Upper Teeth _____ Lower Teeth: _____
Do you have: ☐ Denture ☐ Partial Denture ☐ Bridge
☐ I have had a denture, partial denture or bridge in the past but not any more
Please describe more about your current dental health and needs: _____

_____

_____

Please check all that apply: *(If you have any condition marked * have your physician complete page 9 Medical Triage Form. Attach the completed form to your application when you submit it.)*

☐ Artificial heart valve/stent*
☐ Heart problems*
☐ Diabetes*
☐ Dialysis*
☐ Organ transplant*
☐ Cancer*
☐ Rheumatoid arthritis*
☐ Multiple Sclerosis*
☐ Artificial joint/other orthopedic hardware*
☐ Autoimmune*
☐ Head trauma
☐ Mental health diagnosis

Your dental health can be closely linked to your overall health and may affect your treatment needs, please explain in detail all physical and mental health issues.

Major Disabilities, Health Problems or Things You Take Medication For:

_____
_____
_____
_____
_____
_____

Primary Care Physician's Name: _____
Phone: _____ Fax: _____

Do you use: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Scooter ☐ Hearing Aid ☐ Translator
If you use a wheelchair or scooter, can you transfer to a standard dental chair? ☐ Yes ☐ No

When was the last time you were hospitalized? _____
Why were you hospitalized? _____

Have you taken antibiotics in the last 6 months? ☐ Yes ☐ No

Are there any caseworkers/social workers/medical workers assisting you? ☐ Yes ☐ No

Agency Name: _____
Caseworker Name: _____
Phone: _____ Fax: _____

Are you able to work? ☐ Yes ☐ No
If no, please explain why: _____

If you are employed, place of employment: _____
Your monthly employment income: _____

If you are not receiving disability, have you ever applied? ☐ Yes ☐ No
If no, why not? _____

Is your spouse/significant other employed? ☐ Yes ☐ No
If yes, place of employment: _____
Spouse/significant other's monthly employment income: _____
If no, please explain why: _____

Please list all persons living in the home:

Name of each person in the household	**Age**	**Relationship to You**	**Monthly Income**
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

	Year Began	**Monthly Amount**
Supplemental security income (SSI)	_____	_____
Social security disability income (SSDI)	_____	_____
Social Security (retirement)	_____	_____
Unemployment	_____	_____
Workers Compensation	_____	_____
Temporary Assistance to Needy Families (TANF)	_____	_____
Food Stamps		_____
Other Public Assistance: _____		_____

Total Monthly Household Income: **_____**

Total Value of Savings: _____ Total Value of Pension: _____

Type of Investments/Assets: _____
Total Value of Investments/Assets: _____

Do you have a Medicare Advantage Plan? ☐ Yes ☐ No
*If yes, please send a summary of dental benefits with your application.

Do you have Medicare? ☐ Yes ☐ No
*If yes, type of Medicare plan(s): _____

Do you have Medicaid? ☐ Yes ☐ No
*If yes, do you have: ☐ Traditional Medicaid
☐ Spend Down Monthly Spend Down Amount: _____
☐ Healthy Michigan Plan Name of Plan: _____
*If yes, have you been to a dentist that accepts Medicaid? ☐ Yes ☐ No
Date of last appointment: _____
Treatment Received: _____

How long have you lived where you are now? _____
Do you: ☐ Own ☐ Rent
Who owns the house you live in? ☐ Myself ☐ Significant Other ☐ Landlord ☐ Family Member

	Monthly Payment		**Monthly Payment**
Housing	_____	Cable/Internet	_____
Car	_____	Credit card	_____
Utilities	_____	Other loans	_____
Phone	_____	Life Insurance	_____
Car Insurance	_____	Medications	_____
Health Insurance	_____	Other medical costs	_____
Other car expenses	_____	Other household expenses	_____

Food (not including food stamps): _____ Do you visit food banks? ☐ Yes ☐ No
Other monthly expenses not listed: _____ **Total monthly expenses: _____**

Car Make: _____ Model: _____ Year: _____

Do any family members contribute money toward monthly household expenses? ☐ Yes ☐ No
If yes, please explain: _____

Are you a veteran? ☐ Yes ☐ No

Have you had utilities shut off in the last 12 months? ☐ Yes ☐ No

Have you skipped medications in the last 12 months due to the cost? ☐ Yes ☐ No

In the last 12 months, have you had to go without health care because you didn't have a way to get there? ☐ Yes ☐ No

Have you used your cooking stove or a propane heater for heat? ☐ Yes ☐ No

Do you ever need help reading doctor or hospital materials? ☐ Yes ☐ No

Are you worried that in the next 6 months you might not have stable housing? ☐ Yes ☐ No

Are any other sources available to help (i.e churches, service organizations?) ☐ Yes ☐ No
If yes, please explain: _____

Do you live in subsidized housing? ☐ Yes ☐ No

Do you have someone who helps you manage your health needs/appointments? ☐ Yes ☐ No
Name: _____ Phone: _____
Relationship to you: _____
Is this person able to come with you to appointments? ☐ Yes ☐ No

Do you have significant medical debt? ☐ Yes Amount:_____ ☐ No

What other barriers do you face when trying to get your dental needs met? _____
_____

Are you nervous about seeing a dentist? ☐ Yes ☐ No

How far are you able to travel (in miles) to receive the treatment you need? _____
Will you be using public transportation? ☐ Yes ☐ No
What nearby cities/communities are you able to get to for treatment? _____
_____

What is your primary language? ☐ English ☐ Spanish ☐ Arabic ☐ German
☐ Chinese ☐ French Other: _____

Authorizations/Releases

Please read the following statements carefully before signing. If you understand and agree to the conditions, please sign and date at the bottom of the form.

1. **Agreement – Release of Information**
   a. I understand that I will need to provide personal information that includes but is not limited to medical, dental and financial condition. I authorize the Michigan Donated Dental Services (DDS) program to obtain information from, and share information with my physician(s), dentist(s), contact people I listed, and/or government or private agencies in order to determine my eligibility for the DDS program.
   b. 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 authorize the DDS program to share information with and obtain information about me with one or more dentist(s) volunteering in the DDS program.
   c. I understand if my disability is AIDS or HIV related, I authorize the DDS program and Dental Lifeline Network to release information about my AIDS or HIV-related medical condition to one or more DDS volunteer dentists. I also understand that I have a right to revoke this consent at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it. Furthermore, this consent will expire by _____ or upon the closure of my DDS case.
2. **Eligibility & Treatment Understanding**
   a. I realize that my application to the DDS program does not guarantee I will be referred for an examination or that I will be accepted as a patient following an examination. I understand that the Michigan Dental Association, which coordinates the Michigan DDS program, will determine whether I am eligible for the program and, if so, will try 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.
   b. I understand that the dentist(s) has volunteered to treat my existing dental condition only and is not obligated to provide donated care in the future or to maintain me as a patient.
   c. 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 Michigan DDS program has no responsibility to assist me in obtaining the services of an alternate dentist.
3. **My Responsibilities**
   a. I understand the importance of keeping all scheduled appointments and agree to make them. If I am unable to make a scheduled appointment, I agree to follow the cancellation policies of the volunteer dentist office regarding providing notice.
   b. I agree to communicate regularly with the DDS coordinator assigned to me about the treatment I am receiving, my appointments, and any changes to my health, living situation or financial situation throughout the duration of my treatment.
   c. I agree to follow home care instructions and communicate any issues with the volunteer dentist and DDS coordinator to the best of my ability to give myself the best chance for a successful treatment outcome.
   d. I understand that while I am receiving donated care through the DDS program, I will not be charged any fees by the donating dental office nor the DDS program. Should I wish to continue treatment and

obtain additional services such as cosmetic services or ongoing preventive care, I must wait until my DDS case is closed and enter into a private agreement with the dentist. This is not a part of the DDS program.

e. I agree to work with my dentist to make an informed decision on the best treatment option(s) for me as an individual. I understand that not all treatment options may be available as donated and might not be appropriate for my individual health. Should I disagree with the treatment options offered to me through the program, I may choose to close my DDS case and pursue other services on my own.

4. Covered Entities

I understand that the agreements above apply to all affiliates of the Michigan Donated Dental Services (DDS) program including but not limited to the Michigan Dental Association, Dental Lifeline Network, Michigan Department of Health and Human Services, dentist volunteers within the DDS program, and dental laboratories/supply companies volunteering within the DDS program who may be involved in my treatment.

To the best of my knowledge, the information provided within this application is a full and accurate disclosure of my current physical, medical and financial status.

Signature of client: _____Date:_____

Signature of client's guardian (if needed):_____Date:_____

Please return this completed application and authorization to:

Michigan Donated Dental Services (DDS)
3657 Okemos Rd., Suite 200
Okemos, MI 48864
Fax: 517-372-0008

Medical Triage Form

Only submit this form with your application if you have a medical need for dental treatment.

MUST BE COMPLETED BY YOUR MEDICAL DOCTOR

Patient Full Name: _____Date: _____

Printed Name of Physician: _____

Physician Signature: _____ Physician Phone: _____

Oral Condition

Severity of dental disease:

- ☐ Mild (no obvious decay or periodontal infections)
- ☐ Moderate (obvious decay and/or periodontal infection but not extreme)
- ☐ Severe (rampant decay, teeth fractured and/or mobile, significant periodontal inflammation)
- ☐ Other (please describe) _____

Medical Condition(s)

Organ transplantation: Organ _____ ☐ candidate ☐ recipient

Immunodeficiency: ☐ immune system suppressed by medication/disease (specify _____)

Renal function: ☐ compromised ☐ on hemodialysis ☐ planned hemodialysis

Diabetes: ☐ Type 1 ☐ Type 2 ☐ Controlled ☐ Uncontrolled
☐ Controlled w/Diet ☐ Controlled w/medication

Cancer: Type: _____ ☐ Active ☐ Remission
Chemotherapy ☐ Planned ☐ Active ☐ Completed
Radiation therapy ☐ Planned ☐ Active ☐ Completed

Cardiovascular: ☐ History of bacterial endocarditis ☐ Artificial heart valve ☐ Stent
☐ Valvular heart disease Other:_____

Blood dyscrasia: (Type and severity) _____

Joint prosthesis: ☐ Planned ☐ Present Type: _____

Medications:

- ☐ corticosteroids ☐ immunosuppressive or cytotoxic drugs
- ☐ bisphosphonate therapy ☐ planned ☐ active ☐ completed (how long ago _____)

Please specify medication(s) and the related condition for which the drug is prescribed:

Medication	**Condition Prescribed For**
_____	_____
_____	_____
_____	_____

Medical Necessity of Dental Care

Will medical therapies for the patient be complicated by untreated oral condition? ☐ Yes ☐ No

If yes, please check applicable medical management issues

- ☐ Enhanced immune-suppression concerns/risks
- ☐ Sepsis risks preventing or delaying needed surgery Type: _____
- ☐ Concerns regarding intubation for anesthesia or endoscopy because teeth are mobile or brittle
- ☐ Other: _____

Given medical circumstance(s), are you concerned the person's dental condition poses a significant risk of increased morbidity? ☐ Yes ☐ No

If yes, please grade risk: ☐ **Moderate**, needs care within 6-12 months ☐ **Severe**, needs care within 3-6 months
☐ **Urgent**, present status an unacceptable risk to overall care (abscesses, osteomyelitis, etc.)