



**Dental Lifeline**  
Network • Florida

More than Dentistry. Life.®

1113 E. Tennessee St. Suite 300  
Tallahassee, FL 32308-6914  
Phone: 850.577.1466  
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Fax: 850.577.1467

**Board of Directors:**

Cesar Sabates, DDS  
*President*

Georgina Garcia, DDS  
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Alain Carles  
Mike Eggnatz, DDS  
Thomas Lane, DMD  
Idalia Lastra, DMD  
Edgar Rivera

## 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·Florida.

### ELIGIBILITY:

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

### COST:

Qualifying individuals generally pay nothing, but occasionally, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is necessary.

### DENTAL BENEFITS:

If dental insurance and/or Medicaid cover any portion of your dental problems, you will be asked to exhaust this resource.

### APPLICATION PROCESS:

#### Step One

Complete entire application. Page 4 of the application provides consent for the Program Coordinator to obtain and share information about you, and Page 5 of the application provides consent for your physician to release medical information. Please return the application and both consent forms by mail, fax, or online as directed. Keep this page for your records.

#### Step Two

When your application is received and you appear to be eligible for DDS, your application will be placed on a waitlist in the order it 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. Please also be aware that we cannot return phone calls about where you are on the waiting list due to the volume of calls we receive and trying to help people through the program as quickly as possible.**

#### Step Three

When your application comes to the top of the waitlist, DDS will contact you to tentatively determine eligibility. If a volunteer dentist agrees to evaluate your oral health, you will be given the information 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 a 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,  
Donated Dental Services (DDS) Program Coordinator

**APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM**

Donated Dental Services (DDS)  
1113 E Tennessee St. Suite 300  
Tallahassee, FL 32308

Date of application: \_\_\_\_\_

**APPLICANT INFORMATION**

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ (home)

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ (cell)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male:  Female:  Military Veteran:

Marital status: Single  Married  Divorced  Widowed  Separated

Contact Person Name (relative, friend, etc.): \_\_\_\_\_

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? \_\_\_\_\_

**MEDICAL INFORMATION**

Do you have an artificial heart valve and/or stent? Yes  No  Do you have osteoporosis? Yes  No

Do you receive treatment for heart problems? Yes  No  Do you have rheumatoid arthritis? Yes  No

Are you currently on dialysis? Yes  No  Do you have Lupus? Yes  No

Do you have Crohn's disease? Yes  No  Do you have Multiple Sclerosis? Yes  No

Have you ever had an organ transplant? Yes  No  Do you take Clozaril? Yes  No

Are you currently being treated for cancer? Yes  No

Do you have an artificial joint or other orthopedic hardware? Yes  No

Have you taken any of the following medications; Boniva, Prolia, Fosamax, Reclast, Actonel, Interferon? Yes  No

Has your physician advised you that you need dental care immediately due to a medical condition? Yes  No

Major Disabilities or Health Problems (if your health problem is listed above please explain all in as much detail as possible, also include health problems not listed above):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Physician's name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Do you use a: Wheelchair:  Cane:  Walker:  Scooter:

Do you require wheelchair access? Yes:  No:

**DENTAL INFORMATION**

Briefly describe your dental problems: \_\_\_\_\_

How many natural teeth do you have remaining? # of Upper Teeth: \_\_\_\_\_ # of Lower Teeth: \_\_\_\_\_

Name of last dentist: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Approximate date of last dental visit: \_\_\_\_\_

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: \_\_\_\_\_

**REFERRING AGENCY or AGENCY THROUGH WHICH YOU RECEIVE SERVICES**

Agency name: \_\_\_\_\_

Name of caseworker: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**HOUSEHOLD FINANCIAL INFORMATION**

Number of people in your household: \_\_\_\_\_

<u>Name of each person in the household:</u>	<u>Age:</u>	<u>Relationship to you:</u>	<u>Monthly Income:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MONTHLY HOUSEHOLD INCOME:**

Are you able to work? Yes:  No:

If no, please explain why: \_\_\_\_\_

If you are employed, place of employment: \_\_\_\_\_

Your monthly employment income: \$ \_\_\_\_\_

Is your spouse/significant other employed? Yes:  No:

If no, please explain why: \_\_\_\_\_

If they are employed, Place of employment: \_\_\_\_\_

Spouse's/significant other's monthly employment income: \$ \_\_\_\_\_

**FINANCIAL ASSISTANCE:**

	<u>Monthly amount:</u>	<u>Year benefit began:</u>
SSI or SSDI Payments:	\$ _____	_____
Social Security (retirement):	\$ _____	_____
Unemployment/Workers Compensation:	\$ _____	_____
Temporary assistance to needy families (TANF):	\$ _____	_____
Other Public Assistance: _____	\$ _____	_____
<u>Total Monthly Household Income:</u>	\$ _____	

If you are not receiving disability, have you ever applied? Yes:  No:

Total value of savings: \$ \_\_\_\_\_

Type of investments/assets: \_\_\_\_\_

Total value of investments/assets: \$ \_\_\_\_\_

Do you receive Food Stamps? Yes:  No:  Monthly amount: \$ \_\_\_\_\_

Do you receive Medicaid benefits? Yes:  No:  Medicaid #: \_\_\_\_\_

Do you receive Medicare benefits? Yes:  No:

Do you have a Medicare Advantage Plan? Yes:  No:

Do you have dental insurance? Yes:  No:

**MONTHLY HOUSEHOLD EXPENSES:**

Housing: \$ \_\_\_\_\_ Own:  Rent:

Food (not including Food Stamps): \$ \_\_\_\_\_ Utilities: \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_

Cable/Internet: \$ \_\_\_\_\_ Credit card/Loan payments: \$ \_\_\_\_\_ Medications/Medical Costs: \$ \_\_\_\_\_

Out of pocket health insurance: \$ \_\_\_\_\_ Life/Burial insurance: \$ \_\_\_\_\_

Is there a car in the household? Yes:  No:

If yes, make: \_\_\_\_\_ model: \_\_\_\_\_ year of car: \_\_\_\_\_

Car payment: \$ \_\_\_\_\_ Car insurance/Car expenses/Gas: \$ \_\_\_\_\_

Other Monthly Expenses: \_\_\_\_\_

Total Monthly Household Expenses: \$ \_\_\_\_\_

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: \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Use this space to elaborate on any information not sufficiently explained in other areas:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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(s), dentist(s), 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 dentist volunteering in the DDS program.

In addition, I understand if my disability is AIDS or HIV related, I give the DDS Coordinator of Dental Lifeline Network·Florida permission to release information about my AIDS or HIV-related medical condition to one or more volunteer dentists in the DDS program and hold Dental Lifeline Network·Florida harmless for doing so. 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 \_\_\_\_\_.

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·Florida, which coordinates the 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.

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.

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·Florida 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·Florida 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: \_\_\_\_\_



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Dear Applicant,  
Please complete and sign this form so that we can obtain necessary information.

Dear Medical Provider: \_\_\_\_\_

\_\_\_\_\_  
(Patient Name)

is seeking care through the Donated Dental Services program, a humanitarian initiative through which volunteer dentists and laboratories provide comprehensive care without charge for individuals with mental, physical, and/or medical disabilities.

To better understand the relative clinical circumstances and needs of applicants, we inquire about the possible medical necessity and urgency for dental treatment. We therefore request at your earliest convenience that you please complete and return this form via fax directly to Dental Lifeline Network at 850-577-1467. Please print clearly.

By signing below, the applicant acknowledges understanding of and grants consent for the requested health history information to be shared with Dental Lifeline Network.

Applicant Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

If you have any questions please do not hesitate to call me.

Thank you,

Donated Dental Services (DDS) Coordinator  
1-877-224-3969