Maryland Foundation of Dentistry for the Handicapped
Application for Services

REFERRING AGENCY – IF APPLICABLE

Agency Name: ____

Phone: (____)______________Name of Caseworker:_____________________________________

Address: ____

City, State & Zip: ____

APPLICANT:
Name: Mr. Mrs. Ms. ____

Social Security #: _______________________________ Date of Birth____________________

Race:____

Address: ____

City, State & Zip: __________________________________ County: __________________

Home Telephone: (______)________________ Cell Telephone: (______)__________________

Number of Individuals in Household: ________ Means of Transportation: ________________

MAJOR DISABILITIES OR HEALTH PROBLEMS:______________________________
____
____
____

List of Current Medications with Dosages and Frequency of Use: _________________________
____
____

Please check box if you have had any problems with the following:
☐ Heart ☐ Kidneys ☐ Liver ☐ Allergies to Medications
Please provide explanation if you checked any of the above boxes:
____
____

Please list all major hospitalizations and dates:
____
____

Is the applicant able to work: ______ yes _____ no If yes, please list current employer and job responsibilities:
____
____

Does the applicant require wheelchair access: ________ yes ___________ no

Primary Physician's Name: ____________________________ Phone #: (____) _____________

Specialists Physician's Name: ________________________________ Phone #: (____) ____________

DENTAL NEEDS:

Briefly describe applicant's dental needs:
____
____

Name of last dentist: ________________________________Phone #: (____) ________________
Date of last dental visit: _____________ Services performed: _____________________________

FINANCIAL INFORMATION:

Is the applicant employed? ____ yes ____ no Monthly wages: $___________

Is spouse employed? _____ yes ____ no Monthly wages: $___________

Income from Social Services – Public Assistance $___________
Income from: SSI SSDI PENSION OTHER (**CIRCLE ALL THAT APPLY**) $___________

Total Monthly Household Income: $___________

Does the applicant receive food stamps? ____yes ____ no Amount: $___________
Total Value of Savings/Investments: $___________

Does the applicant have Medical Assistance? ____yes ____ no
Please list your medical insurance provider, your policy number and their customer service number (located on the back of your insurance card):____
____
Does the applicant have any dental insurance? ________ yes ________ no
If yes, please explain dental coverage: ____

MONTHLY EXPENSES:

Housing	$_______	Phone	$_________	Food	$_________
Utilities	$_______	Water	$_________	Medications	$ _________
Car Payment	$_______	Car Insurance	$________	Gas/car expense	$_________
Health Insurance	$_______	Other	$____		

Total Monthly Household Expenses: $_________________

Does the applicant own a car? ____ yes ____ no Make, model and year of car: ____________

Are family members able to contribute to applicants' dental costs? ______ yes _______ no

CONSENTS:

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 conditions.

I give my consent for the coordinator to obtain information relevant to my eligibility for the DDS program from my physician, dentist, individuals who know me and/or government or private agencies. I give permission to the coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the DDS Program.

I realize that application to the DDS program does not ensure I will be referred for an examination or that I will be accepted as a patient following examination. I understand that the Maryland Foundation of Dentistry for the Handicapped, which coordinates the Donated Dental Services 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 the Foundation, is solely responseible for diagnosis and any possible treatment that I might receive for my dental needs.

In understand that the dentist(s) have volunteered to treat my existing dental condition and are not obligated to provide donated care in the future or to maintain me as a patient.

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hours notice to the dentist, and will disqualify me for obtaining further dental 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.

Signature of Client: ________________________________ Date: _____________

Signature of Guardian: ______________________________ Date: _____________

Optional Photo and Information Consent Form:

"I give permission to the MD Foundation of Dentistry for the Handicapped to use my name information, statements, or photograph for public relations purpose, 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 Foundation 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 Foundation 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 ______________________________________Date_______

Revised 1/24/17