MFDH
Maryland Foundation of Dentistry for the Handicapped
DONATED DENTAL SERVICES

Hello:
In response to your recent inquiry about the availability of free dental care, we are pleased to provide the following information about the Donated Dental Services Program.

ELIGIBILITY: Dentists throughout the state have volunteered to provide comprehensive dental care at no charge to people of all ages, who, because of a serious disability of impaired mental and/or physical health, lack adequate income to pay for needed dental care. All patients admitted into the program must have transportation to the dental office and must keep all appointments. The Donated Dental Services Program is unable to provide sedation services for simple procedures, such as x-rays and cleanings. Dental services are provided free of charge to eligible individuals.

APPLICATION PROCEDURES:

Step One: Please complete, sign, and return the enclosed application.

Step Two: When your application has come up for review, a patient-care coordinator will call to obtain additional information. Please do not call to check on the status of your application. These phone calls take up much of our time and only delay treatment time for all of our clients. A coordinator will call you when your application is up for review.

Step Three: The patient-care coordinator will send a referral with the patient's information to a volunteer dentist.

Step Four: You will be contacted by a dentist's office to schedule an appointment. It is very important that you do not miss any appointments or arrive late. Failure to keep appointments and be on time will result in termination from program.

Upon receipt, your application will be placed on our waiting list. Please be patient. Due to program limitations, we now have an 18-24 month waiting list in some counties. Therefore, we are unable to provide emergency care. The patient care coordinator will contact you when your application has come up for review.

Sincerely,

Lilian Marsh
DDS Executive Director

Chip Newton
Patient Care Coordinator

Shelly McFarland
Patient Care Coordinator

Nikole Garland
Patient Care Coordinator

MFDH 8901 Herrmann Drive Columbia MD 21045

Revised
8-30-2017

Please include a copy of your SSI/SSDI award letter with this application.

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