



## Texas Donated Dental Services Program Eligibility, Rules & Regulations

In response to your recent inquiry about the availability of free and low-cost dental care, we are pleased to provide the following information about the Texas Donated Dental Services (TXDDS) Program.

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### PROGRAM CRITERIA

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We can only accept those applicants who meet at least one of the following two criteria below, show that there is no other means of obtaining needed dental care, and are uninsured and not eligible for any state dental health programs.

1. Individuals who are 55 years or older.
2. Individuals who have a permanent disability and receive disability benefits. *(Please note that proof of disability is required with completed application. As proof, we will accept your approved disability letter, a copy of your disability check stub or a written letter from your physician stating that you're permanently disabled on their company letterhead. If proof is not submitted with your application, you will be automatically denied.)*

If you do not meet at least one of the two criteria above, then you do not qualify for services through the TXDDS program.

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### GUIDELINES

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1. **You must be on time for all of your appointments.**
2. **If you cannot make an appointment, you must call the dentist's office at least 24 hours in advance to cancel it.**
3. **If you miss an appointment without calling at least 24 hours in advance, your treatment will be terminated.**
4. **The dental treatment plan will be determined by the volunteer dentist. If you do not accept the treatment plan, you have the option to drop out of the program, but the treatment plan will not be changed.**
5. **You must be respectful to the volunteer dentist and their office staff. Any inappropriate behavior will be grounds for termination.**
6. **The TXDDS program's main goal is to improve the oral health of our patients and not solely for cosmetic reasons. Therefore dental implants, veneers and bleaching are usually not included in treatment plans.**
7. **The dentist(s) have volunteered to only treat existing dental conditions and are not obligated to provide donated care in the future or to retain you as a patient.**

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### COST OF PROGRAM

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Texas Donated Dental Services is a program of the Texas Dental Association Smiles Foundation, a non-profit organization and we are honored to help serve your current dental needs at no charge to qualifying individuals. All volunteer dentists donate their time and they do not get paid for the services provided.

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### APPLICATION PROCEDURES

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Step 1: Please complete, sign, and return the enclosed application to the TXDDS office. (Address on last page)

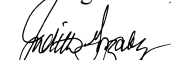
 Step 2: A postcard will be placed in the mail when your application has been processed. All applications are processed once a month at the end of every month. If you do not receive a response within 6 weeks from the date you sent the application, please resubmit your application.

Step 3: This program operates on a first-come, first-serve basis. When your application reaches the top of the waiting list, a TXDDS caseworker will call to obtain additional information and begin the process of matching you with a dentist in your area. If you do not meet the eligibility requirements you will be notified by mail.

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**Due to overwhelming demand, the waiting list at this time is over 3 years long.** The program caseworker will contact you when your application comes up for review. We are sorry that you are experiencing dental problems, and we hope that Texas Donated Dental Services may be a source for some help.

Creating Smiles,



Judith Gonzalez  
TXDDS Manager  
512/448-2441

**APPLICATION FOR TEXAS DONATED DENTAL SERVICES (TXDDS) PROGRAM**

Date of Application: \_\_\_\_\_ 2009

**QUALIFICATION – Please Check ONE box below:**

I am over the age of 55 yrs old, I do not have the means of obtaining dental care, and I'm uninsured for dental care and not eligible for any state dental health programs.

I have a permanent disability and cannot obtain employment, I do not have the means of obtaining dental care, and I'm uninsured for dental care and not eligible for any state dental health programs. I have enclosed documentation as proof of my disability. *(Please note that proof of disability is required with completed application. As proof, we will accept your approved disability letter, a copy of your disability check stub or a written letter from your physician stating that you're permanently disabled on their company letterhead. If proof is not submitted with your application, you will be automatically denied.)*

**APPLICANT INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: Single Divorced Sex: Male or Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Separated Married

How will you get to appointments? \_\_\_\_\_

Please list other cities within traveling distance: \_\_\_\_\_

**If we do not have a volunteer dentist in your area, you will be required to travel to receive services through the TXDDS program**

**Contact person (relative, friend, etc.)**

1. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

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

1. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
3. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
4. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
5. Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**MEDICAL INFORMATION**

List all major disabilities and health problems: \_\_\_\_\_

List medications you are taking: \_\_\_\_\_

Do you take medication for high blood pressure/hypertension? yes or no

Do you require pre-medication? yes or no If yes, please explain: \_\_\_\_\_

Do you require wheelchair access? yes or no

Do you use any tobacco products? yes or no If yes, Frequency? \_\_\_\_\_

Do you receive Medicaid? yes or no If yes, Medicaid # \_\_\_\_\_

If no, are you eligible to receive Medicaid benefits? yes or no If yes, please explain: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Physician's phone #: \_\_\_\_\_

Date of last physician appointment: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**FINANCIAL INFORMATION**

**MONTHLY INCOME FOR APPLICANT:**

Are you able to work? yes or no

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

Are you employed? yes or no

Place of employment: \_\_\_\_\_

Your monthly wages: \$ \_\_\_\_\_

Hours worked per week: \_\_\_\_\_

**MONTHLY INCOME FOR ADDITIONAL HOUSEHOLD MEMBERS:**

Do you live with your spouse, parent(s), significant other or child over 25? yes or no

Are they employed or receiving public assistance? yes or no

Place of employment or type of public assistance: \_\_\_\_\_

Monthly wages or amount of public assistance: \$ \_\_\_\_\_

If they are unemployed, why? \_\_\_\_\_

**PUBLIC ASSISTANCE FOR APPLICANT:**

Do you receive public assistance? yes or no ---- If yes, please fill out below

<u>Programs</u>	<u>Monthly amount</u>	<u>How long have you received benefits?</u>
<input type="checkbox"/> SSI	\$ _____	_____
<input type="checkbox"/> Social Security Disability	\$ _____	_____
<input type="checkbox"/> AFDC	\$ _____	_____
<input type="checkbox"/> Social Security	\$ _____	_____
<input type="checkbox"/> TANF	\$ _____	_____
<input type="checkbox"/> Unemployment	\$ _____	_____
<input type="checkbox"/> Other:	\$ _____	_____

**TOTAL MONTHLY HOUSEHOLD INCOME: \$ \_\_\_\_\_** (include all other household members)

Do you have any savings? \_\_\_\_\_

If yes, total amount of savings: \_\_\_\_\_

Total value of investments: \_\_\_\_\_

Type of investments: \_\_\_\_\_

Do you receive food stamps? yes or no

If yes, monthly amount: \_\_\_\_\_

**MONTHLY EXPENSES:**

Housing: \$ _____	Gas/electricity: \$ _____	Water/sewer: \$ _____
Phone: \$ _____	Food (not including food stamps) \$ _____	House items: \$ _____
Health ins.: \$ _____	Life/burial ins.: \$ _____	Cable: \$ _____
Medications: \$ _____	Medical costs: \$ _____	Credit card(s): \$ _____

Do you own a car? yes or no

Do you currently have a car payment? yes or no

Car payment: \$ \_\_\_\_\_

Car insurance: \$ \_\_\_\_\_

Gas/car exp: \$ \_\_\_\_\_

Pay-off date: \_\_\_\_\_

Make, model, and year of car: \_\_\_\_\_

Other: \_\_\_\_\_

**TOTAL MONTHLY HOUSEHOLD EXPENSES:** \$ \_\_\_\_\_ (include all household expenses)

**DENTAL NEEDS**

Please explain your dental problems: \_\_\_\_\_

Do you have dental insurance? yes or no If yes, please explain: \_\_\_\_\_

Do you need more than a cleaning? yes or no Please explain: \_\_\_\_\_

Do you need dentures/partials? yes or no Please explain: \_\_\_\_\_

Do you currently wear dentures/partials? yes or no How old are they? \_\_\_\_\_

If yes, what problems do you currently have with your dentures/partials? \_\_\_\_\_

Name of last dentist: \_\_\_\_\_ Phone#: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**Could you contribute financially toward the cost of your dental lab expenses?** yes or no

Are any family members able to contribute to costs of your dental treatment? yes or no

If yes, please explain: \_\_\_\_\_ Amount of contribution: \$ \_\_\_\_\_

Are any other sources available to help pay for dental care? yes or no

If yes, please explain: \_\_\_\_\_

**REFERRING AGENCY**

How did you hear about the TXDDS program? \_\_\_\_\_

Agency name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name of caseworker: \_\_\_\_\_ Psychologist name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**ADDITIONAL INFORMATION**

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

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

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**MEDICAL RELEASE FORM**

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**Please read the following statements and initial each line, then sign and date at bottom of page**

**▼ Read each statement and Initial each blank.**

\_\_\_\_\_ I understand that I will need to provide personal information that includes but is not limited to medical, dental, and financial Information to anyone involved in your dental treatment.

\_\_\_\_\_ I give my consent to the Texas Dental Association Smiles Foundation to obtain information relevant to my eligibility for the TXDDS program from my physician, dentist, individuals who know me, and/or government or private agencies.

\_\_\_\_\_ I give permission to the Texas Dental Association Smiles Foundation to share pertinent information about my eligibility with one or more volunteer dentist in the TXDDS program. If my disability is AIDS or HIV related, I give Texas Dental Association Smiles Foundation (TDASF) permission to release information about my medical condition and hold TDASF harmless for doing so.

\_\_\_\_\_ I realize that applying to the TXDDS program does not assure that I will be referred for an examination or that I will be accepted as a patient following an examination. I may be dropped at any time due to non-compliance with the guidelines.

\_\_\_\_\_ I understand that the Texas Dental Association Smiles Foundation, which coordinates the TXDDS 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 responsible for diagnosis and any possible treatment that I might receive for my dental needs.

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

\_\_\_\_\_ I understand that I must accept the treatment plan the volunteer dentist has decided for me. If I do not accept the treatment plan, I have the option to drop out of the program.

\_\_\_\_\_ I understand that the TXDDS program is not intended to include implants, veneers, and bleaching in the treatment plan, it is the TDASF goal to improve my oral health and not solely for cosmetic reasons.

\_\_\_\_\_ I understand that the TXDDS program can refuse dental services to anyone at anytime.

\_\_\_\_\_ If I miss an appointment without a 24 hour notice or if I'm disrespectful, argumentative, or conduct myself inappropriately at any time during the treatment, I will be automatically dropped from 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 client's guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of person referring (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE NOTE:** *Proof of your disability is required with completed application. As proof, we will accept your approved disability letter, a copy of your disability check stub or a written letter from your physician stating that you're permanently disabled on their company letterhead. If proof is not submitted with your application, you will be automatically denied.*

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**SEND APPLICATION TO:**

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Texas Dental Association Smiles Foundation  
**Texas Donated Dental Services (TXDDS)**

1946 South IH 35, Suite 300  
Austin, TX 78704