Dental OPTIONS Application

2138 Madison Avenue Toledo, OH 43604
(419) 776-1009 local or 1-888-765-6789 toll free
(419) 776-1031 fax

Name	Home Phone ( ) Cell Phone ( )
Street Address	Sex □ Male □ Female
City, State, Zip	County
Date of Birth	Age
Race White African-American American Indian/Alaskan Native Asian/Pacific Islander □Other	Hispanic Yes No
Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated	
How long have you lived at the address above? years months	Number of people in household:

Please list all people living in the household below:

Also applying for OPTIONS?	Name	Date of Birth	Relationship	Race
□ Yes □ No				
□ Yes □ No				
□ Yes □ No				
□ Yes □ No				
□ Yes □ No				
□ Yes □ No				

List contact person *not* living with you	Phone ( )	Relationship to you
Complete Address		
How did you hear about Dental OPTIONS?	Were you in the program before? □ Yes, When? _____ □ No	
Major disabilities or health problems for each person applying: _____ _____ _____ _____		
List primary doctor's name	Phone ( )	Do you require wheelchair access? □ Yes □ No

SOURCES OF INCOME / PUBLIC ASSISTANCE FOR ENTIRE HOUSEHOLD:

Is the head of household employed? (circle) Yes No Place of employment _____
Monthly wages (gross pay, before taxes are taken out) $ _____
If unemployed, please explain _____

Is the spouse/significant other employed? (circle) Yes No Place of employment _____
Monthly wages (gross pay, before taxes are taken out) $ _____
If unemployed, please explain _____

Are other any other members of the household employed? (circle) Yes No

Name: _____ Place of employment _____
Monthly wages: $_____ (gross pay, before taxes taken out)

Name: _____ Place of employment _____
Monthly wages: $_____ (gross pay, before taxes taken out)

Does anyone in your household receive any of the following? If yes, please submit proof (not originals) for all income listed below. Without proof of income application will be considered incomplete.

Types of other income:	**Monthly Amount**	**When did it begin?**
Child Support		
Food Stamps		
Pension/Retirement		
Social Security (SS)		
Supplemental Security Income (SSI)		
Social Security Disability Income (SSDI)		
Temporary Assistance for Needy Families (TANF/ADC)		
Unemployment Benefits		
Veteran's Administration Pension (VA)		
Worker's Compensation		
Other (list source)		

Total monthly household income:
$

Savings:

Total amount of savings: $	Total amount of investments: $	Type of investments (IRA, etc.):

Insurance Information:

Do you have dental insurance? □ Yes □ No If yes, please list name of insurer and policy number:

Do you receive Medicaid benefits? □ Yes □ No

If yes, does it include dental coverage? □ Yes □ No Explain _____

If yes, do you have a spend-down? □ Yes □ No How much? $ _____

Monthly expenses for entire household:

Housing $	Car Payment $	Credit Cards $
Home/Renter's Insurance $	Car Insurance $	Child Support $
Home/Cell Phone $	Gas/Car expense $	Day Care $
Gas $	Health Insurance $	Other: $
Electricity $	Medical Costs $	Other: $
Water/Sewer $	Medications $	Other: $
Food $	Life/Burial Insurance $	Other: $

Total monthly household expenses:
$

Dental History:

Name of last dentist you saw:	Phone: ( )
Date of last dental visit (estimate if necessary):	Reason for visit:

Current Dental Needs (briefly describe dental needs of <u>each</u> applicant):

_____

_____

_____

_____

Transportation:

Do you have a car for transportation? □ Yes □ No If yes, make, model and year of car:

How will you get to your appointments?
□ Self □ Friend/relative □ Bus □ Taxi

Additional Information (Please use this space to explain any additional information you feel Dental OPTIONS should have):

_____

_____

_____

Application review checklist (INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED):

- ✓ Did you answer <u>all</u> questions?
- ✓ Did you submit proof of <u>entire</u> household income (please send copies, proof of income will not be returned)? (i.e., most recent 3 paystubs, most recent W2 form, public assistance/benefit award letters)
- ✓ Did each applicant sign the back page of the application?

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 Referral Coordinator to obtain information, relevant to my eligibility for the Dental OPTIONS Program, from my physician, dentist, individuals who know me and/or government or private agencies.
- I give permission for the Referral Coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the Dental OPTIONS Program.
- I realize that my application to the Dental OPTIONS 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 the Dental OPTIONS Program Referral Coordinator 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 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 treat my existing dental condition only and are not obligated to provide donated/discounted care in the future or to maintain me as a patient
- The Dental OPTIONS Program (and its sponsoring organizations) serves as a referral source only. Dentists participating in the Dental OPTIONS Program shall not be considered agents of the Dental OPTIONS Program or its sponsoring organizations. The Dental OPTIONS Program (and its sponsoring organizations) does not investigate dentists who participate in the program and accepts no responsibility for the treatment provided by the dentists under the program.
- I agree to submit any appropriate controversy or claim arising out of my treatment under the Dental OPTIONS Program to the Ohio Dental Association Peer Review Process.
- I understand that if I am eligible for the Dental OPTIONS Program, I am responsible for paying the appropriate fee agreed to by the dentist and me.
- I hereby authorize the Dental OPTIONS Program to collect and complete information from my dentist for all services rendered. I understand that the information will be used to gauge the success of the Dental OPTIONS Program and that specific information will be kept strictly confidential.
- I understand the importance of keeping all scheduled appointments. Failure to do so 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, mental and financial status.

Each person, over the age of 18 and applying for Dental OPTIONS, must sign below:

Signature of applicant	Date
Signature of any additional applicants (if necessary)	Date
Signature of client's guardian (if necessary)	Date
Signature of person referring or helping to complete application May we contact you for assistance in working with this applicant, if necessary? □ Yes □ No If yes, contact information (please print): Name: _____ Phone: (___) _____	Date

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Income	Family Size	DDS/DFA