

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

ILLINOIS DONATED DENTAL SERVICES PROGRAM
ZELLER MENTAL HEALTH CENTER
5407 NORTH UNIVERSITY
PEORIA, IL 61614
(309) 689-6785 OR (800) 699-6785

DATE OF APPLICATION: _____
HAVE YOU RECEIVED SERVICES THROUGH
THE DDS PROGRAM BEFORE? YES NO

APPLICANT

NAME: _____ PHONE: _____

ADDRESS: _____ PLEASE CIRCLE: MALE FEMALE

CITY, STATE, ZIP: _____ COUNTY: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOW DID YOU HEAR ABOUT THE DDS PROGRAM? _____

CONTACT PERSON (RELATIVE, FRIEND, ETC.):

NAME: _____ PHONE: _____

RELATIONSHIP TO YOU: _____

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _____

NAME OF EACH PERSON	AGE	RELATIONSHIP TO YOU
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAJOR DISABILITIES OR HEALTH PROBLEMS (EXPLAIN IN AS MUCH DETAIL AS POSSIBLE):

DO YOU REQUIRE WHEELCHAIR ACCESS? YES NO

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____

FINANCIAL INFORMATION

MONTHLY INCOME:

ARE YOU ABLE TO WORK? YES NO

IF NO, PLEASE EXPLAIN: _____

ARE YOU EMPLOYED? YES NO PLACE OF EMPLOYMENT: _____

YOUR MONTHLY WAGES: \$ _____

IS YOUR SPOUSE EMPLOYED? YES NO PLACE OF EMPLOYMENT: _____

SPOUSE'S MONTHLY WAGES: \$ _____

IF SPOUSE IS UNEMPLOYED, WHY? _____

PUBLIC ASSISTANCE:

PROGRAM	MONTHLY AMOUNT	HOW LONG HAVE YOU RECEIVED BENEFITS?
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SSI: _____

SOCIAL SECURITY DISABILITY: _____

TANF: _____

SOCIAL SECURITY: _____

UNEMPLOYMENT: _____

OTHER: _____

OTHER: _____

TOTAL MONTHLY HOUSEHOLD INCOME: \$ _____

TOTAL VALUE OF SAVINGS: _____

TOTAL VALUE OF INVESTMENTS: _____

TYPE OF INVESTMENTS: _____

FOOD STAMPS? YES NO MONTHLY AMOUNT: \$ _____

MONTHLY EXPENSES:

HOUSING: \$ _____ PHONE: \$ _____ FOOD(NOT INCL. FOOD STAMPS): \$ _____

GAS/ELECTRICITY: \$ _____ WATER/SEWER: \$ _____ CAR PAYMENT: \$ _____

CAR INSURANCE: \$ _____ GAS/CAR EXP: \$ _____ HEALTH INSURANCE: \$ _____

LIFE/BURIAL INS.: \$ _____ MEDICATIONS: \$ _____ MEDICAL COSTS: \$ _____

OTHER: _____

OTHER: _____

OTHER: _____

TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ _____

DENTAL NEEDS

BRIEFLY DESCRIBE YOUR DENTAL NEEDS: _____

NAME OF LAST DENTIST: _____ PHONE#: _____

DATE OF LAST DENTAL VISIT: _____

HOW WILL YOU GET TO DENTAL APPOINTMENTS? _____

PLEASE LIST OTHER TOWNS YOU CAN GET TO: _____, _____,

_____?

DO YOU RECEIVE MEDICAID BENEFITS? YES NO MEDICAID # _____

DO YOU HAVE DENTAL INSURANCE? YES NO

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: _____

Do you own a car? yes no

Make, model, and year of car: _____

REFERRING AGENCY

AGENCY NAME: _____ PHONE: _____

NAME OF CASEWORKER: _____

ADDRESS: _____

CITY, STATE ZIP: _____

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 referral 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 for the referral coordinator to share pertinent information, about my eligibility, with one or more volunteer dentist in the DDS program. If my disability is AIDS or HIV related, I give the Foundation of Dentistry for the Handicapped (FDH) permission to release information about my medical condition and hold FDH harmless for doing so.

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 the Foundation of Dentistry for the Handicapped, which coordinates the DDS 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 treat my existing dental condition only and are not obligated to provide donated care in the future or to maintain me as a patient.

I understand that 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, mental and financial status.

Signature of client: _____ Date: _____

Signature of client's guardian: _____ Date: _____
(if necessary)

Signature of person referring (if applicable): _____ Date: _____