



The Donated Dental Services program provides free dental care to eligible applicants. Volunteer dentists, specialists, and dental laboratories offer comprehensive dental treatment to eligible applicants. DDS volunteers give their time and use their resources to provide the services to you.

Please carefully review the following program requirements.

If you have already been through our program, please do not apply again. The DDS program is a once-in-a-lifetime program.

Core Eligibility Requirements: To be eligible for the DDS program, you must meet **ONE** of the following three requirements:

- 62 years of age or older, or
- Permanently disabled and receiving SSI or SSDI, or
- Medically Compromised -Need life-saving care and can't get treatment unless you treat your oral health.

In addition, you must meet **ALL** of the following criteria:

- You have not received services through the DDS program in the past,
- Low Income - We do have income limits for determining eligibility. In general, your income can be no higher than 150% of the Federal Poverty Guidelines. However, we do look at other factors when determining whether or not you meet the low-income requirement For example, we consider medical bills you may be paying when looking at your income. We also considered the assets you own, such as vehicles.
- You **MUST** have reliable transportation. If you miss a scheduled appointment, you may be at risk of being dropped from the program. Please only apply if you have reliable transportation and will not have any issues making your scheduled appointments.
- You require comprehensive dental care (more than just routine cleaning, a filling or two)
- The dental care you need is a service provided through the DDS program. Please note, implants, sedation dentistry, and other types of extensive oral surgery are not covered under the DDS program. Some cases are too complex for the DDS program.

Required Documentation – Income Verification:

Please return the completed application with a copy of **ONE** of the following required documents.

- A copy of your most recent federal tax return (if applicable),
- A copy of your Disability Benefits Statement confirming your disability and your monthly income (if applicable) or, A copy of your Social Security Benefits Statement documenting your monthly income (if applicable).

After reviewing your application, we may determine that additional documentation is needed.

DENTAL BENEFITS: If you have dental insurance, especially Medicaid, you will need to use that first. Please provide a copy of your dental coverage and/or a letter of denial with your application.



WAITLIST: Unfortunately, due to the overwhelming number of individuals needing dental care in Virginia, the DDS program must maintain a waitlist. If you are eligible for our program, you will be placed on the waiting list. We are not able to provide you with an estimated wait time. Your time on the waitlist will depend on several factors, such as the part of the state you live in, how many volunteers are currently working with patients, and how long the treatment plans are for active patients.

APPLICATION PROCESS:

Step One

Fill out the entire application the best that you can. Do not leave any sections blank. If a question does not apply to you, write N/A. If you are disabled, please include proof of disability (e.g., SS Award Letter) with your application.

Step Two

Once we receive your completed and signed application, we will determine if you are eligible for the DDS program, and we will contact you. It generally takes 35 to 40 days to process new applications. If you are eligible, we will let you know the next steps. If you are not eligible, we will explain why and provide you with other resources that may help you.

If you are eligible, you will be placed on the waiting list in the order that your application was received. ***Depending on where you live, the wait can be several months, or the wait can be over a year.**

Step Three

When your application comes to the top of the waitlist, DDS will contact you and go over the application with you. If you are eligible, you will be referred to a volunteer dentist. If a volunteer agrees to accept your case, we will provide you with the information you need to get started.

Final acceptance into the program will be made after your first appointment with the dentist. Once we receive your treatment plan, we will be able to determine if the care you need is a service provided under the Donated Dental Program. Additionally, you may initially qualify for the program but may become ineligible later if your circumstances change while you are on the waitlist. Once you are next on the waiting list, we may require additional documentation to confirm that you are still eligible for the program.

We are sorry you are having a dental problem. We hope the Donated Dental Services (DDS) program may be of some help.

You will need to mail, scan and email, or fax your complete and SIGNED application by:

- Mail: DDS Program, 3460 Mayland Drive, Suite 110, Richmond, VA 23233
- Fax: (804) 523-1880
- Email: PJordan@vadental.org

***Please note – we cannot accept photos of your application via email. If you cannot scan your application, please mail it to our office. Please keep a copy for your records.**

Penny J. Jordan, Donated Dental Services (DDS) Program Manager
Address: 3460 Mayland Court, Suite 110, Richmond, VA 23233
Phone: (804) 523.2182
Email: [*pjordan@vadental.org](mailto:pjordan@vadental.org)

Donated Dental Services (DDS)

Frequently Asked Questions and Answers

1. I have a dental emergency. Can you help? We do not offer emergency treatment. There is a waiting list for treatment, and it can often take 4 to 8 weeks to find a dentist to accept your case when you are next on the waitlist. Additionally, the dentists are volunteers who fit you into their busy schedules, and they cannot handle emergency cases that require immediate attention. If you are in pain and need emergency care, call (804) 523-2182 or email pjordan@youraaa.org. We can send you a list of agencies in your area that may be able to help you with your emergency. When you no longer need immediate care, you may be eligible for the DDS program.

2. What kind of dental care can I get through the DDS program? The DDS program provides comprehensive, non-emergency dental care based on the treatment plan provided by your volunteer dentist. If you disagree with or request a different treatment plan, you are no longer eligible for the DDS program.

Routine dental care such as cleanings and one or two fillings are not covered. Since the services and materials are donated (dentures, crowns, etc.), the most cost-effective manner will be taken without compromising quality. Cosmetic needs are not the focus. Living pain-free and being able to eat properly is what we are working towards.

The DDS program does not cover implants, sedation, and certain types of extensive oral surgery. Some cases are too complex for the DDS program.

3. How will I know if you received my application? Applications are processed within 35 days of receipt. If you have not received a phone call or email from the DDS coordinator after 35 days, please call (804) 523-2182 to check on the status.

4. How can I find out where I am on the waitlist or how long my wait is? Unfortunately, we cannot answer questions about wait times and where you are on the waitlist. Many factors affect the wait time, such as the availability of volunteer dentists and the length of time it takes for active patients to complete their treatment plans.

5. How far will I have to travel? We make every effort to place you with a dentist near you. We never place you with a dentist that is more than 30 miles away unless we absolutely must due to a lack of dental resources in your area.

6. Are the dentists paid? The dentist and oral surgeons are not paid. They are volunteering their time to provide you with free dental care. We ask that you be respectful and gracious when working with your volunteer dentists. In addition, any material needed for things such as dentures and crowns is donated by dental labs.



Foundation
VIRGINIA DENTAL ASSOCIATION

**Donated Dental
Services (DDS)**



Donated Dental Services (DDS)

RETURN APPLICATION TO:
Donated Dental Services (DDS)
3460 Mayland Ct. Ste. 110
Richmond, VA 23233
AX: 804-288-1880

APPLICANT INFORMATION

Name: _____ Phone: h) _____ c) _____

Address: _____

City: _____ State: _____ Zip: _____ County (if applicable): _____

Email: (if available) _____

Date of Birth: ____/____/____ Age: _____ Please Note: Female Male

Military Veteran: Yes No

Marital Status: Single Married Divorced Widowed Separated In partnership

Race: Asian Black Hispanic Other Unknown White

Alternate Contact: _____ Relationship to you: _____

Phone: _____ Email: _____

How did you hear about our Program? Agency/Name: _____

Case Manager/Social Worker: _____ Phone: _____

Should we contact your case manager/social worker about your application? Yes No

Email: _____ Fax: _____

List the Names, Ages and Incomes of ALL members of your household (Use Back of Page if Needed)

Number of people living in your household: _____

Name of each person	Age	Relationship to you	Monthly Income

For office use only: App #: _____

Date Received ____/____/____ Initial Status (Pending / Denied, reason _____) NLS ____/____/____

Intake ____/____/____ Closed ____/____/____ Final Status (Closed / Terminated, reason _____)

HEALTH HISTORY- We may share the information you provide with a prospective volunteer dentist

Your Primary Care Physician's name: _____ Phone: _____

Please circle any of the health conditions that apply to you:

- | | | | |
|--------------------------|------------------|-------------------------------|-------|
| Adrenal Disease | Diabetes Type I | Mental Health Illness | _____ |
| Artificial joints | Diabetes Type II | Peptic Ulcer | _____ |
| Arthritis | Heart Disease | Renal Disease | _____ |
| Asthma | Heart Murmur | Rheumatic Heart Disease/Fever | _____ |
| Bleeding disorders | Hepatitis | Shortness of Breath | _____ |
| Bronchitis/chronic cough | HIV/AIDS | Smoker | _____ |
| Cancer | Hypertension | Recent Surgeries | _____ |

Please explain your major disabilities or health concerns:

Please list the medications you take: (prescriptions, over the counter, vitamins, inhalers, etc.):

Please list any medications you are allergic to, and the reaction you had from taking the medication:

IF MORE ROOM IS NEEDED FOR ILLNESSES, MEDICATIONS, OR ALLERGIES, PLEASE ATTACH A SEPARATE SHEET OF PAPER

DENTAL INFORMATION

Previous Dentist: _____ Phone: _____

Date of last exam: ____/____/____ Services Performed: _____

Tell us about your dental needs (*please be specific – number of teeth missing or present, how many issues?*):

Upper: _____

Lower: _____

Do you require wheelchair access? _____ Yes _____ No

Are you pregnant/nursing or planning to become pregnant? _____ Yes _____ No

FINANCIAL INFORMATION

Are you able to work? Part-time _____ Yes _____ No Full-time _____ Yes _____ No
If no, please explain

Are you employed: _____ Yes _____ No Monthly wages (before taxes): _____

Place of Employment: _____

Is your spouse employed? _____ Yes _____ No Monthly wages: (before taxes) _____

Spouse's Place of Employment: _____

If your spouse is unemployed, please explain: _____

INCOME INFORMATION: *(your application is not complete until we receive proof of income documentation)*

Use \$0 if you do not receive income from a source listed below.

TOTAL HOUSEHOLD INCOME (Not including your income) _____

YOUR SSDI/SSI: _____ Date Started Receiving: _____

SOCIAL SECURITY: _____ Date Started Receiving: _____

RETIREMENT _____ Date Started Receiving: _____

SNAP: _____ Date Started Receiving: _____

TANF: _____ Date Started Receiving: _____

UNEMPLOYMENT: _____ Date Started Receiving: _____

CHILD SUPPORT _____

OTHER INCOME: _____ Source of Income: _____

YOUR MONTHLY EXPENSES: Housing: (Own or Rent) _____ Monthly Housing Expense: _____

Phone: _____ Utilities: _____ Cable/Internet: _____

Food: (not including SNAP) _____ Car Payments: _____ Car Insurance: _____

Credit Cards/Loan Payments: _____ Bus/other Transportation: _____ Gas: _____

Health Insurance: _____ Life/Burial Insurance: _____

Medication: _____ Other Medical costs: _____ Other: _____

TOTAL MONTHLY HOUSEHOLD EXPENSES: \$ _____

TRANSPORTATION

Having reliable transportation is a requirement for the Donated Dental Services program.

How will you get to your dental appointments? _____

Please list other towns you are able to get to easily _____, _____, _____

Can you drive to dental appointments? _____

Please Provide the Year, Make, and Model of Each Vehicle in your Household:

INSURANCE

Do you receive Full Medicaid benefits? _____ Yes _____ No If yes, please list member # _____

(Note: If you receive Full Medicaid benefits, you must use your Medicaid Dental Coverage first. Please provide a copy of your dental coverage or a letter of denial with your application.

Do you receive Medicare benefits? _____ Yes _____ No

Do you have dental insurance? _____ Yes _____ No If yes, through what company? _____

Are you able to make payments toward your dental treatment? _____ Yes _____ No If yes, how much \$ _____

Have you ever participated in the Donated Dental Services Program before? _____ Yes _____ No

Are there any other sources available to help pay for your dental care? (i.e. churches, service organizations, other agencies) _____ Yes _____ No If yes, please explain: _____

ADDITIONAL INFORMATION

How would this program help you, or impact your life?

Is there anything else you would like to share with the volunteer dentists considering your case?

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, SIGN AND DATE THE FORM AT THE BOTTOM. WE WILL NOT CONSIDER YOUR APPLICATION WITHOUT A SIGNATURE BELOW.

Regarding Information Sharing:

I understand I will need to provide personal information, which includes, but is not limited to medical, dental, and my financial condition.

I give my consent for the project coordinator to obtain information relevant to my eligibility for the Donated Dental Service (DDS) program from my physicians, dentists, individuals who know me, and/or government or private agencies.

I give permission for the project coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the DDS program. If my disability is AIDS or HIV related, I give the Virginia Dental Association Foundation (VDAF), which coordinates the DDS program, permission to release information about my medical condition and hold VDAF harmless for doing so.

I realize applying 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 have provided a complete, accurate disclosure of my current physical and mental health as well as financial status on this application.

Please Note: Any information concerning my case, including pictures or videos in which I may appear, are the property of the Virginia Dental Association Foundation (VDAF), and may be used in newsletters, brochures, journals, grant proposals, or other promotional materials.

Regarding Treatment: (In the event that we are able to connect you with a dentist)

I understand 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 the dentist, NOT DDS, is solely responsible for diagnosis and any possible treatment I might receive for my dental needs.

GOAL: To restore your mouth to good oral health

I understand that volunteers (dentists, their staffs, and labs) donate all services to you as a gift. Since services and materials (dentures, crowns, etc.) are donated, the most cost-effective manner will be taken without compromising quality. Cosmetic needs are not the focus. Living pain-free and being able to eat properly are what we are working towards.

I understand that the DDS Program may not cover implants, sedation, or certain types of extensive oral surgery. Unfortunately, we do not have access to hospitals where certain types of surgeries must be performed. **Certain cases are simply too complex for this program.**

I understand the dentist(s) have volunteered to treat my **existing dental condition only** and are not obligated to provide dental care in the future or to maintain me as a patient. I further understand I am only eligible for services through the DDS program ONE TIME, and it is my responsibility to find follow-up dental care to maintain good oral health.

I understand that the volunteer dentist will determine my treatment plan. Due to the limited number of volunteer dentists, Donated Dental Services will not reassign me to another dentist if I do not agree with the proposed treatment plan.

I am aware that at my first appointment, oral surgery or extractions may be part of my treatment.

Patient Responsibilities: Failure to adhere to any of these items may result in termination of your care.

We must be able to communicate by phone and mail with you or an advocate throughout your care. We request that you notify us of any changes of address or phone while in our program.

You must have reliable transportation to get you to and from dental appointments on time; preferably 15 minutes early. At your first appointment, you may need to complete paperwork. We hope you will plan accordingly to allow enough time for that before your scheduled appointment.

If you must cancel or reschedule an appointment, then do so 24-48 hours or more in advance.

If you require help getting around the dental office or in and out of the chair, please bring someone with you to your appointment that can assist you. If you have difficulty hearing or speak a foreign language, please bring someone with you who can help you communicate with the dentist.

We hope you will discuss continual care of your teeth or dentures with your dentist prior to the end of your treatment. It is your responsibility to keep up with brushing, flossing, annual checkups, etc.

NOTE: We are not an emergency service. Please be prepared to wait for services. Some areas of Virginia could have as long as a 2 year wait for services. We will hold your application for 2 years from the date we receive it.

A SIGNATURE IS REQUIRED TO PROCESS THE APPLICATION.

Signature of Applicant: _____ Date: _____

Signature of Applicant's Guardian: _____ Date: _____

Donated Dental Services (DDS)

Medically Compromised Questionnaire

If you believe you are eligible for the DDS Program because you are Medically Compromised, please answer the questions below. If you answer “yes” to any of the questions, you will need to have your treating physician complete the **Medical Triage Form** included in this packet. The Medical Triage Form will need to be included with your completed application.

1. Do you have an artificial heart valve and/or stent? Yes _____ No _____
2. Do you receive treatment for heart disease? Yes _____ No _____
3. Are you currently on dialysis? Yes _____ No _____
4. Do you have a current dental infection? Yes _____ No _____
5. Have you ever had an organ transplant? Yes _____ No _____
6. Are you currently being treated for cancer? Yes _____ No _____
7. Do you have osteoporosis? Yes _____ No _____
8. Do you have rheumatoid arthritis? Yes _____ No _____
9. Do you have Lupus? Yes _____ No _____
10. Do you have Multiple Sclerosis? Yes _____ No _____
11. Do you take Clozaril? Yes _____ No _____
12. Do you have Crohn’s disease? Yes _____ No _____
13. Do you have an artificial joint or other orthopedic hardware? Yes _____ No _____
14. Have you taken any of the following medications: Boniva, Prolia, Fosamax, Reclast, Actonel, Interferon?
Yes _____ No _____
15. Do you have a Major Disability or Health Condition not listed that would be exacerbated by neglected dental needs? Yes _____ No _____ *if you answered yes, please provide details below

Other Major Disabilities or Health Conditions

Please provide details about any major disability or health conditions you have that are not listed above. Include the date you were diagnosed, symptoms, treatments, etc. Use the back of the page, in necessary.

Donated Dental Services (DDS) - Medical Triage Form To Be Completed by Physician

DDS is dedicated to helping individuals with disabilities, older adults, and the medically fragile/compromised. We need your help to prioritize the dental needs of your patient.

Patient Name _____

Medical Necessity of Dental Care:

Given medical circumstance(s), are you concerned the person's dental condition poses a significant risk of increased morbidity? ___ Yes ___ No (If the answer is no, do NOT proceed with the remainder of the form)

*If yes, please grade risk:

- ___ Moderate, needs dental care completed within six to twelve months
- ___ Severe, needs dental care within three to six months
- ___ Urgent, present status an unacceptable risk to overall care (i.e., abscesses, osteomyelitis)

Medical Condition - please check all that apply

- ___ Sepsis concerns because patient is immunocompromised by:
 - ___ Disease(s) - Specify: _____
 - ___ Immunosuppressant/Cytotoxic drugs - Specify: _____
- ___ Infection of existing or planned orthopedic prosthesis / hardware
- ___ Infection of existing or planned implanted vascular / valvular / cardiac devices
- ___ Recipient of or candidate for organ transplant (type) Date of Transplant: ___ / ___ / ___
- ___ Poorly managed diabetes (date and level of last A1C) _____
- ___ History of endocarditis, valvular heart disease
- ___ History or current use of bisphosphate drugs for cancer, osteoporosis (clarify if such drugs are:
 - ___ Planned, ___ Currently being used, ___ Completed (year discontinued) _____
- ___ Recurrent pulmonary complications (infection, COPD, aspiration)
- ___ Planned surgical, endoscopic, or intubation being postponed because of brittle / loose / infected teeth
- ___ Dysphagia risking aspiration because of missing teeth & impaired mastication
 - *Dysphagia is related to which disease? _____
- ___ Serious risk that severe dental infection may create abscesses/dissecting cellulitis
- ___ Patient requires recurrent use of antibiotics and/or opioid drugs because of unresolved dental infections
- ___ Other _____

Oral Condition

Severity of disease:

- ___ Mild (no obvious decay or periodontal infections)
- ___ Moderate (obvious decay and/or periodontal disease but not extreme)
- ___ Severe (rampant decay, teeth fractured and/or mobile, significant periodontal inflammation)
- ___ Other; please describe _____

Physician Name: _____

Physician Signature: _____ Date: _____

Physician Address: _____

Physician Phone: _____



**Donated Dental
Services (DDS)**



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Donated Dental Services (DDS)

PHOTO AND INFORMATION CONSENT FORM

COMPLETING THIS FORM IS OPTIONAL.

I authorize the Virginia Dental Association Foundation to use my name, information, statements, or photographs for public relations purposes and 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 organization's programs and encourage involvement from dental professionals and funders. I also agree that no material needs to be submitted to me for further approval, and I give the organization the right to copyright such material if necessary.

I understand that providing consent is entirely at my discretion.

I understand that my eligibility and the services I receive through the Donated Dental Services program will not be affected in any way if I choose not to provide my consent.

Signature: _____ Date: _____

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