Dentists Who Care SMILE Voucher Program

Dear Applicant:

The following pages are the SMILE Voucher Program Application.

Who Are We?

Dentists Who Care (DWC) is a private, non-profit charitable organization created to help solve the problem of poor Oral Health among children and adults in the Rio Grande Valley. The mission is to improve and enhance the quality of life for low income children and adults in the Rio Grande Valley of Texas through access to oral health care.

ELIGIBILITY:

Dentists in the Rio Grande Valley volunteer to service our clients that can't afford dental treatment. If you are in pain and qualify, Dentists Who Care will refer you to a participating dentist and issue a voucher (value $300) toward the cost of dental care.

If you have no insurance, no Medicaid or you are low income; you may qualify for free treatment. Patient must live in the Rio Grande Valley area. You are eligible to receive services once a year (from the date of last service).

COST:

If you qualify, you may not need to pay for anything. From time to time, people who can pay for part of their care may be asked to do so at a reduced fee or like when laboratory work is needed.

APPLICATION PROCESS:

Step One

Fill out the entire application the best that you can and explain briefly why you need our services. Do not leave any session blank.

Step Two

When we get your application, we will decide if you appear eligible for the program. If so, we will put you on the waiting list in the order your application was received. If you are not eligible, we will contact you by phone or email.

We operate with volunteers, donations and grants so at times the wait may take a few days to months.

Step Three

When your application comes to the top of the waitlist, Dentists Who Care 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 see you, you have 30 days from the date of the issued voucher to schedule an appointment.

APPOINTMENTS:

If you no show or do not call dentist within 24 hours to cancel appointment, you will become ineligible for future service.

We are sorry you having a dental problem. We hope the Charity Voucher Dental Program may be of some help.

Sincerely,

Mary Mendez

Program Coordinator

Please keep this page for your records.

 Name:_____

APPLICATION FOR DENTISTS WHO CARE

Dentists Who Care, INC
307 E. Railroad Street #112
Weslaco, TX 78596
Office: 956- 318-3383
Fax: 956-467-4776
Email:
dentistswhocare@gmail.com

For Internal Use Only:

Application ID: _____ Date entered: _____

Circle One: Approved Denied Date: _____

Refer to Dentist:_____

Date of application: _____

APPLICANT INFORMATION

Name: _____ Phone: (____) _____(home)

Address: _____ Phone: (____) _____(cell)

City: _____ State: _____ Zip Code:_____ County:_____

Email Address: _____

Date of birth: _____ Age: _____ Male:____ ☐ Female: ☐ **Military Veteran:** ☐ (include copy of DD 214)

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Emergency Contact (relative, friend, etc.):_____

Phone: (____) _____ Relationship to you: _____

Have you received services through the Dentists Who Care program before? ☐ Yes ☐ No If yes, in which city?_____

How did you hear about the SMILE Voucher Program?_____

MEDICAL *INFORAMTION*

Asthma	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐	Fainting	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Chicken Pox	Yes ☐ No ☐	Heart Problems	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Measles	Yes ☐ No ☐
Mumps	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Sinus Problems	Yes ☐ No ☐	Thyriod Disease	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	A.I.D.S/H.I.V	Yes ☐ No ☐

Major Disabilities or Health Problems (Please explain in as much detail as possible; include date diagnosed, symptoms, treatment, etc.):

_____

_____

_____

_____

Please list all medications you are taking:_____

_____

_____

Primary Physician's Name: _____

Phone: (___)_____ Fax: (___)_____

Do you use a: Wheelchair: ☐ Cane: ☐ Walker: ☐ Scooter: ☐

Do you require wheelchair access? Yes: ☐ No: ☐

DENTAL INFORMATION

Name of last dentist:_____ Approximate date of last dental visit:_____

How will you get to dental appointments:_____

Please list other cities or how far you are willing to travel in order to get dental treatment:_____

Do your gums bleed during flossing? ☐ Yes ☐ No Do you feel pain in any certain tooth? ☐ Yes ☐ No
Do your stuff from any frequent headaches? ☐ Yes ☐ No Have you ever had any orthodontic treatment? ☐ Yes ☐ No
Do your teeth hurt when drinking hot or cold drinks ☐ Yes ☐ No

Briefly describe your dental problems:_____

_____

_____

REFERRING SCHOOL OR COMMUNITY CENTER (Organization)

School or Community name:_____

Name of Nurse:_____ Name Principal:_____ Phone: (___)_____

Address: _____ Fax: (___)_____

City: _____ State:_____ Zip:_____

HOUSEHOLD FINANCIAL INFORMATION

Number of people in your household: _____

Name of each person in the household:	Age:	Relationship to you:	Monthly Income:
_____	____	_____	_____
_____	____	_____	_____

MONTHLY HOUSEHOLD INCOME:

Are you able to work? Yes: ☐ No: ☐

If no, please explain why: _____

If you are employed, place of employment: _____

Your monthly employment income: $_____

If your spouse/significant other employed? Yes: ☐ No: ☐

If no, please explain why: _____

If they are employed, Place of employment:_____

Spouse's/significant other's monthly employment income: $_____

FINANCIAL ASSISTANCE: Monthly amount: Year benefit began:

SSI or SSDI Payments (Provide copy of Award Letter): $_____ _____

Social Security (retirement): $_____ _____

Unemployment/Workers Compensation: $_____ _____

Temporary assistant to needy families (TANF): $_____ _____

Other Public Assistance: _____ $_____ _____

Do you receive Food Stamps? Yes: ☐ No: ☐ Monthly amount: $_____

Do you receive Medicaid benefits? Yes: ☐ No: ☐

Do you have Medicare benefits? Yes: ☐ No: ☐

Do you have a Medicare Advantage Plan? Yes: ☐ No: ☐

Do you have dental insurance? Yes: ☐ No: ☐ *(If Yes, Provide copy of Dental Benefits)*

ADDITIONAL INFORMATION:

Statement of need: (financial hardship/health etc.):

_____

_____

_____

_____

_____

(FOR OFFICE USE ONLY)

INCOME TABLE (BELOW):

As of March 6, 2017

Household Size	Extremely Low Income (30%)	Very Low Income (50%)	Low Income (80%)
1 Person	$11,000	$18,350	$29,350
2 Persons	$12,600	$21,000	$33,550
3 Persons	$14,150	$23,600	$37,750
4 Persons	$15,700	$26,200	$41,900
5 Persons	$17,000	$28,300	$45,300
6 Persons	$18,250	$30,400	$48,650
7 Persons	$19,500	$32,500	$52,000
8 Persons	$20,750	$34,600	$55,350

APPROVAL: ☐ Yes ☐ No BY:_____DATE:_____

AGREEMENT

Please read the following statements

If you understand and agree to the conditions please sign and date the form below

Agreement- Release of Information

a) I understand that I will need to provide personal information that includes but, is not limited to medical, dental, and financial condition. I authorize the Dentists Who Care SMILE Voucher Program to obtain information from, and share information with my physician(s), dentist(s), contact people I listed, and/or government or private agencies in order to determine my eligibility for the Dentists Who Care SMILE Voucher Program.

b) I understand information provided by me or others as noted may be given only to the volunteers involved in my treatment and will be held confidential. I authorize Dentists Who Care SMILE Voucher Program to share and obtain about me with one or more dentists(s) volunteering in the Dentists Who Care Charity.

c) I understand if my disability is AIDS or HIV related, I authorize the SMILE Voucher Program and Dentists Who Care to release information about my AIDS or HIV-related medical condition to one or move volunteer dentists in the SMILE Voucher Program and hold Dentists Who Care harmless for doing so.

d) I also understand that I have a right to revoke this consent at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it. Furthermore, this consent will expire at either the termination or completion of my treatment through the Dentists Who Care SMILE Voucher.

Eligibility & Treatment Understanding

a) I realize that my application to the Dentists Who Care SMILE Voucher program does not assure I will be referred for an examination or that will be accepted as a patient following an examination. I understand that Dentists Who Care, which coordinates the SMILE Voucher Program, will determine whether I am eligible for the program and, if so, will try to refer me to a participating volunteer dentist. I further understand that the dentist, not the organization, is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

b) I understand that the dentist(s) has volunteered to treat my existing dental condition only and is not obligated to provide donated care in the future or to maintain me as a patient.

c) I understand that a volunteer dentist in the Dentists Who Care SMILE Voucher Program may discontinue providing services to me at any time upon reasonable notice provided to me. I understand that, after receiving such notice. I am responsible for obtaining the services of an alternate dentist. I also understand that Dentists Who Care SMILE Voucher Program had no responsibility to assist me in obtaining the service of an alternate dentist.

My Responsibilities

a) I agree to find and obtain reliable transportation to and from all dental appointments. Also, I agree to arrive on time to all of my appointments and will make every effort to arrive 15 minutes early prior to the time of my appointment.

b) I agree to keep all appointments unless I have a serious emergency and rescheduling is unavoidable. If I have an emergency and I am unable to keep an appointment, I will follow the dentist's policy regarding cancellation and call the dentist's office to cancel my appointment at least 24-48 hours in advance. I understand that if I miss an appointment without calling in advance or reschedule or cancel more than one appointment, I may be terminated from the Dentists Who Care SMILE Voucher Program.

c) I shall not ask the Dentists Who Care SMILE Voucher volunteer dentist for pain medication and understand that medication will only be supplied or prescribed to me by the dentist when it is absolutely necessary and at the dentist's discretion.

To the best of my knowledge, the information provided in this application is a full and accurate disclosure of my current physical, medical, and financial status and I agree to the terms and conditions stated above:

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

Printed name of client**: _____ Date: _____**

this form must be signed and dated prior to acceptance into the Dentists Who Care SMILE Voucher Program

 Name:_____

Photo and Information Consent Form (Optional)

I authorize Dentists Who Care, Inc. to use my name, information, statements, or photograph for public relations purposes, 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 organization 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 organization 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 Dentists Who Care SMILE Voucher Program.

Signature of client: _____ Date: _____

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