Dental OPTIONS Application
5550 Venture Drive
Parma, Ohio 44130
(216) 201-2063 local or 1-888-765-6789 toll free
(216) 676-1323 fax; TTY (216) 676-1313

Print Form

Name:	Home Phone: Cell Phone :
Street Address:	Sex Male: ☐ Female: ☐
City, State, Zip:	County:
Date of Birth:	Age:
Race: African-American: ☐ American Indian/Alaskan Native: ☐ Asian/Pacific Islander: ☐ White: ☐ 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? If yes, When?	No: ☐
Major disabilities or health problems for each person applying:		
Primary doctor's name:	Phone:	Do you require wheelchair access? Yes: ☐ No: ☐

Sources of Income / Public Assistance for entire Household:

Monthly household income	Yes/No	Place of Employment	Monthly wages (gross pay before taxes are taken out)
Is head of household employed?	Yes: ☐ No: ☐		$
If unemployed, please explain:			
Is the spouse/significant other employed?	Yes: ☐ No ☐		$
If unemployed, please explain:			
Are any other members of the household employed?	Yes: ☐ No: ☐	Place of Employment	Monthly wages (gross pay before taxes are taken out)
Name:			$
Name:			$
Other types of income:		When did it begin?	Monthly Amount
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 of all sources of income (monthly household income plus other types of income).			**$** 0.00

Please send proof of all income listed with your application. (please send copies, proof of income will not be returned)
If you are employed, include your 3 most recent paystubs. If you are receiving other income, send public assistance or benefit award letters. Without proof of income your application will be considered incomplete.

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, is dental coverage included? Yes ☐ No ☐	Explain:
If yes, do you have a spenddown? Yes ☐ No ☐	How much? $

Monthly expenses for the 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:
$ $0.00

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):

FOR YOUR APPLICATION TO BE CONSIDERED, YOU MUST:

- ✓ Answer <u>all</u> questions.
- ✓ **<u>SEND PROOF OF ENTIRE HOUSEHOLD INCOME</u> (please send copies, proof of income will not be returned) If you are employed, include your 3 most recent paystubs. If you are receiving other income, send public assistance or benefit award letters.**
- ✓ Have 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.

- 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 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

- 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:

OFFICE USE ONLY

Income:	Family Size:	DDS/DFA: