

Sources Of Income/Public Assistance

Monthly Income For Household

Is the head of household employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of employment
Monthly wages (<i>gross pay, before taxes are taken out</i>) \$	If unemployed, why?
Is anyone else in the household employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of employment
Monthly wages (<i>gross pay, before taxes are taken out</i>) \$	If unemployed, why?

Does your household receive

Other income	Monthly amount	How long?
Child support?		
Pension/retirement?		
SSI?		
SSDI?		
TANF (ADC)?		
Worker's Comp?		
Social Security?		
Food stamps?		
Unemployment?		
Other? (<i>list source</i>)		

Total monthly household income \$

Please submit proof (**not** originals) for all income listed above. *Proof will not be returned to you.*

Savings

Total amount of savings account	Total amount of investments
Type of investment (IRA, money market account, etc.)	Make, model and year of car

Insurance information

Do you receive Medicaid benefits? Yes No

Do you have dental insurance? Yes No

If yes, name of insurer and number

Monthly expenses for household

Housing \$	Phone \$	Food \$
Gas/Electricity \$	Water/Sewer \$	Car payment \$
Car insurance \$	Gas/Car expense \$	Health insurance \$
Life/Burial insurance \$	Medications \$	Medical cost \$
Child support \$	Credit cards \$	Day care \$
Other \$	Other \$	Other \$

Total monthly household expenses \$
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Dental needs

Briefly describe the dental needs of each applicant.

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Name of last dentist you saw	Phone ()
Date of last dental visit	Reason
How will you get to your appointments? <input type="checkbox"/> Yourself <input type="checkbox"/> Friend/relative <input type="checkbox"/> Bus/taxi	
If friend/relative, name and phone	Phone ()

Additional information

Use this space to elaborate on any information not sufficiently explained in other areas.

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For your application to be considered, you must:

- complete all questions. All questions must be answered.
- submit financial information from previous page.
 - ▼ pay stubs, W2 form, or recent income tax return
 - ▼ public assistance proof
 - ▼ award letters
 - ▼ other income proof
- sign the back page.

Incomplete applications will not be considered.

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Income	Family size	DDS/DFA
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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.

Signature of client	Date
Signature of client's guardian (if necessary)	Date
Signature of person referring or helping to complete application	Date
May we contact you for assistance in working with this client, if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone number ()