MFD
Maryland Foundation of Dentistry
DONATED DENTAL SERVICES

Greetings.

The following information describes the Maryland Foundation of Dentistry's (MFD) Donated Dental Services Program. MFD is a nonprofit organization that coordinates free dental services statewide for qualified adults. Visit mfd-dds.org to learn more about the organization.

ELIGIBILITY: Dentists throughout the state of Maryland volunteer to provide comprehensive dental care in their private offices at no charge to people 18 years and older (including Veterans), who, because of a disability, impaired mental and/or physical health, lack adequate income to pay for needed dental care.

All patients admitted into the program must have transportation to the dental office and must keep all appointments or provide sufficient notification if cancelling is necessary. If you are accepted into the program, services are offered one time per patient. Services to restore oral health and dental function include crowns, bridges, dentures, oral cancer screenings, root canals, and tooth extractions. **MFD does not offer implants, emergency or sedation services.**

DENTAL BENEFITS: If you have private dental insurance, you are not eligible for this program.

APPLICATION PROCEDURES AND REVIEW PROCESS:

Step One: Complete, sign, and return the accompanying application. A patient care coordinator will call you when your application is up for review, or you will receive notification if your application is denied. Call 410-964-1944 with any changes in your information for your application to remain updated. **Please include a copy of your SSI/SSDI award letter with this application. Submit your application either by:**

- **Mail: Maryland Foundation of Dentistry, 8901 Herrmann Dr. Columbia, MD 21045**
- **Email: info@mfdh.org**
- **Fax: 410-964-9978**

Step Two: When your application comes up for review, a patient care coordinator will call to set up a phone interview and obtain additional information that will determine if you're eligible for the program.

Step Three: If you are accepted, the patient care coordinator will send a referral with your information to a volunteer dentist in your community.

Step Four: You will be contacted by the dentist's office to schedule appointments. It is very important that you do not miss any appointments or arrive late. **Failure to keep appointments and be on time will result in termination from the program.**

If you have any questions, contact us at 410-964-1944.

Sincerely,

Chip Newton
Patient Care Coordinator

Erin Sorzano
Patient Care Coordinator

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Donated Dental Services Application

REFERRING AGENCY – IF APPLICABLE

Agency Name:_____

Phone: (____)_____

Name of Caseworker:_____

Address: _____

City, State & Zip:_____

APPLICANT:

Name: _____

Gender: Female ___ Male ___ Non-binary ____

Race:_____ Social Security # **(Last 4 digits only**) _____

Date of Birth _____ Age _____

Address:_____

City, State & Zip: _____

County:_____

Home Telephone: (_____)_____ Cell Number (_____)_____

Email address _____

Number of Individuals in Household: _____

Do you use a wheelchair?: ____ yes ____ no Veteran Status: ____ yes _____ no

Do you have reliable transportation for getting to all appointments? ____ yes _____ no
Mode(s) of Transportation: _____

Does the applicant have Medical Coverage? ____ yes ____ no Dental insurance? ____ yes ___no

If yes, please explain dental coverage:

_____

Please list your medical and dental insurance provider, your policy number, and the customer service number (located on the back of your insurance card):

_____

_____

Are you able to work?: _____ yes _____ no

If yes, please list current employer and job responsibilities:

_____

_____

LIST DISABILITIES AND/OR HEALTH PROBLEMS:

_____

_____

_____

_____

List current medications with dosages and frequency of use: (Please use an additional sheet if needed)

_____

_____

_____

_____

Please check the boxes below if you have had (or have) problems with the following:

☐ Heart ☐ Kidneys ☐ Liver ☐ Allergies to Medications

Please provide an explanation if you checked any of the above boxes:

_____

_____

_____

Please list all major hospitalizations and dates:

_____

_____

_____

_____

Primary Physician's Name: _____ Phone #: (____) _____

Physician: _____ Specialty: _____ Phone #: (____) _____

Physician: _____ Specialty: _____ Phone #: (____) _____

Physician: _____ Specialty: _____ Phone #: (____) _____

DENTAL NEEDS:

_____

_____

_____

_____

Name of last dentist: _____ Phone #: (____)

Date of last dental visit: _____

Services performed:_____

_____

_____

FINANCIAL INFORMATION:

Are you employed? ____ yes ____ no Monthly wages: $_____

Is spouse/partner employed? _____ yes ____ no Monthly wages: $_____

Income from Social Services – Public Assistance $_____

Income from (**circle all that apply**): SSI SSDI Pension Other $_____

Total Monthly Household Income: $_____

Does the applicant receive food stamps? ____ yes ____ no Amount: $_____

Total Value of Savings/Investments: Amount:$_____

MONTHLY EXPENSES:

Housing $ _____ Phone $_____ Food $ _____

Utilities $ _____ Cable/Internet $_____ Water $_____

Medications $ _____ Car Payment $_____ Car Insurance $_____

Gas/car expense $_____ Health Insurance $_____ Other $ _____

Total Monthly Household Expenses: $_____

Is there anything else you would like to add to your application?

_____

_____

_____

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CONSENTS:

Please read the following statements. If you understand and agree to the conditions, 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 patient care 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 to the patient care coordinator to share pertinent information about my eligibility with one or more volunteer dentists in the DDS Program.

I realize that application to the DDS program does not ensure I will be referred for an examination or that I will be accepted as a patient following examination. I understand that the Maryland Foundation of Dentistry (MFD), which coordinates the Donated Dental Services (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 MFD, 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 and are not obligated to provide donated care in the future or to maintain me as a patient.

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hours' notice to the dentist, will disqualify me for obtaining further dental 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.

Name of Applicant (printed) _____

Applicant Signature _____

Date _____

Name of Guardian/Power of Attorney _____

Guardian/Power of Attorney Signature _____

Date: _____

Optional Photo and Information Consent Form:

I give permission to MFD 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 shared with donors/prospective donors and/or in dental journals, website(s), media stories, advertisements or other marketing materials that promotes the MFD program and encourages 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 MFD the right to copyright such material if necessary. **I understand that if I do not grant this permission, it will not affect my eligibility for receiving services through Donated Dental Services.**

Applicant name (print) _____

Applicant Signature_____

Date_____

Guardian/Power of Attorney (print): _____

Guardian/Power of Attorney Signature _____

Date _____