



APPLICATION FOR OPTIONS PROGRAM

Dental OPTIONS
246 N. High St.
Columbus, Ohio 43215
1-888-765-6789

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_ Sex (circle) Male Female

City, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ \*Social Security Number \_\_\_\_\_

Race (circle) White African Hispanic American Indian/ Asian/
American Alaskan Native Pacific Islander

Marital Status (circle) Single Married Divorced Widowed Separated

How long have you lived at the address above? \_\_\_\_\_ months \_\_\_\_\_ years

Number of people in the household \_\_\_\_\_ Please list below.

Table with 7 columns: Yes, No, Name, Date of Birth, Relationship, Soc. Sec. No., Race. Multiple rows for listing household members.

Contact person not living with you: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Complete address: \_\_\_\_\_

How did you hear about the Dental OPTIONS Program? \_\_\_\_\_

Major disabilities or health problems (explain in as much detail as possible): \_\_\_\_\_

Family doctor's name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Do you require wheelchair access (circle)? Yes No

\*Disclosure of a social security number is voluntary and will be used to identify patients enrolled in the Dental OPTIONS Program. Social security numbers will be kept confidential and will not be released without approval of the applicant. Pursuant to Revised Code 3701.027, refusal to provide a social security number will not affect eligibility.

**SOURCES OF INCOME/PUBLIC ASSISTANCE**

**MONTHLY INCOME FOR HOUSEHOLD:**

Is the head of household employed (circle)? Yes No Place of employment \_\_\_\_\_

Monthly wages \$ \_\_\_\_\_ (gross pay, before taxes are taken out)

If unemployed, why? \_\_\_\_\_  
\_\_\_\_\_

Is the spouse employed (circle)? Yes No Place of employment \_\_\_\_\_

Spouse's monthly wages \$ \_\_\_\_\_ (gross pay, before taxes are taken out)

If spouse is 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? (list source)		

**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 (circle)? Yes No

Do you have dental insurance (circle)? 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 \$** \_\_\_\_\_

**DENTAL NEEDS**

Briefly describe dental needs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of last dentist you saw \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Reason \_\_\_\_\_

How will you get to your appointments (circle)? Yourself      friend/relative      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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.**

**FOR OFFICE USE ONLY:**

Income \_\_\_\_\_ Family size \_\_\_\_\_

DDS      DFA \_\_\_\_\_

**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 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?**    **Yes**                      **No**

**Telephone number (      )** \_\_\_\_\_