**APPLICATION FOR DENTAL CARE ASSISTANCE**

OICF and Medical Teams International, along with dentists and volunteers, are collaborating to provide dental care to Orcas residents. Dental Van dates will be posted on the library drop-off box and published in local press releases. All information provided will be handled confidentially. Applicants with appointments will be contacted prior to the clinic. If you are not contacted, please submit a new application at least two weeks prior to the next clinic date. **Please note that completing this application does not guarantee an appointment**. Patients with the greatest need will be given priority. If you have any questions or require assistance with completing the form, please contact Rita Bailey or Barbara Ehrmantraut, Orcas Island Site Coordinators at orcasdentalvan@gmail.com (preferred) or 360-298-2791 (Rita) 360-376-3395 (Barbara). Completed applications are accepted at the Public Library in the outside drop box marked, “Dental Van”, on the side of the building.

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School/Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (if patient is a minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (mailing and physical, if different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been seen on the dental van before: YES NO

Best contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alt. contact number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: (if preferred method of contact)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have dental insurance? YES NO

Please indicate (if known), what dental care you may require. Please number in order of priority from 1-5.

 **EXTRACTION \_\_\_\_\_\_\_\_\_**

 **FILLING \_\_\_\_\_\_\_\_\_**

 **CLEANING/EXAM \_\_\_\_\_\_\_\_\_**

Last time teeth cleaned:\_\_\_\_\_\_\_

 **CROWN \_\_\_\_\_\_\_\_\_**

 **DENTURE \_\_\_\_\_\_\_\_\_**

There are limited opportunities for a crown or denture and there will be a lab fee that needs to be collected for this service. Currently, there are no root canals performed on the dental van.

Do you have any pain in your mouth?

YES NO

Do you have any swelling in your mouth?

YES NO

Are you experiencing any sensitivity?

YES NO

If yes, please describe.

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

Please describe any pain, swelling or decay you have (i.e. where is this located, **how long have**

**you had this** and what have you done for relief). General description of dental needs:

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

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

January 2014

Last time you saw a dentist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving dental care or treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health issues or concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL VAN SCREENING GUIDELINES**:

Individuals accepted for treatment on the dental van MUST 1) have incomes less than 200% of the federal poverty level, 2) have no dental insurance of any kind, and 3) have no realistic ability to pay for the urgent dental care they need.

|  |  |
| --- | --- |
| Family Size | 200% FPL |
| 1 | $21,780 |
| 2 | $29,420 |
| 3 | $37,060 |
| 4 | $44,700 |
| 5 | $52,340 |
| 6 | $59,980 |
| 7 | $67,620 |
| 8 | $75,260 |

Total income from all sources for household:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are extenuating circumstances you would like us to consider, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Location application was obtained (i.e. Food Bank, WIC, OFC, library):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need any special services? (i.e. translation)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred day/time (are there any limitations to when you can be scheduled? i.e. work on Saturdays, etc). Clinics run from 8-3 and we cannot guarantee that we can accommodate scheduling requests.

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

I certify that that the information provided is true and complete to the best of my knowledge and that I do not have any insurance to cover these costs:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE USE ONLY:

Date Application received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Income guideline met: YES NO

Priority: I - PAIN/INFECTION

II - DECAY

 III - PROPHY FMD

Scheduled clinic date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow up care required:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contacted patient (date and initials):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_