(Revised 2018) DATE_____

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) 360-298-5358 (Barbara). **COMPLETED** applications (incomplete applications may not be considered) 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: _____Age: _____ 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**

Preferred method of contact: **Phone** **Text** **Email**

Best contact number: _____Alt. contact number:_____

May we text you? _____Email: (preferred)_____

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: 1 yr or less _____ 1-3 yrs _____ 5+ yrs_____10+_____

ARE YOU EXPERIENCING PAIN? _____ Level on a scale of 1-10_____

Please describe the pain/discomfort:

_____

_____

ANY SWELLING OR INFECTION? YES _____ NO_____

Last time you saw a 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 (2017 chart below) 2) have no dental insurance of any kind, or cannot access dental care on your current insurance, and 3) have no realistic ability to pay for the urgent dental care they need.

Family Size	200% FPL
1	$24,120
2	$32,480
3	$40,840
4	$49,200
5	$57,560
6	$65,920
7	$74,280
8	$82,640

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 usually run from 8-3 on Friday and Saturdays 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):