

APPLICATION FOR DONATED ORTHODONTIC SERVICES (DOS) PROGRAM

KANSAS DONATED ORTHODONTIC SERVICES
PO Box 4266
TOPEKA, KS 66604
(785) 273-1900 OR (888) 870-2066
(785) 273-1542 - FAX

DATE OF APPLICATION: _____

APPLICANT

CHILD'S NAME: _____

PARENT OR GUARDIAN'S NAME: _____ PHONE: _____

ADDRESS: _____ PLEASE CIRCLE: MALE FEMALE

CITY, STATE, ZIP: _____ COUNTY: _____

CHILD'S DATE OF BIRTH: _____ AGE: _____

HOW DID YOU HEAR ABOUT THE DOS PROGRAM? _____

CONTACT PERSON (RELATIVE, FRIEND, ETC.):

NAME: _____ PHONE: _____

RELATIONSHIP TO CHILD: _____

NUMBER OF PEOPLE IN CHILD'S HOUSEHOLD: _____

NAME OF EACH PERSON	AGE	RELATIONSHIP TO CHILD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL INFORMATION

HOUSEHOLD MONTHLY INCOME:

PARENT OR GUARDIAN #1 _____

ARE YOU EMPLOYED? ___ YES ___ NO PLACE OF EMPLOYMENT: _____

YOUR MONTHLY WAGES: \$ _____

PARENT OR GUARDIAN #2 _____

ARE YOU EMPLOYED? ___ YES ___ NO PLACE OF EMPLOYMENT: _____

YOUR MONTHLY WAGES: \$ _____

FINANCIAL INFORMATION (CONTINUED)

ARE THERE ANY OTHER SOURCES OF INCOME FOR YOUR HOUSEHOLD, SUCH AS SOCIAL SECURITY, SSI, TANF, UNEMPLOYMENT, CHILD SUPPORT, ETC.)? IF SO, PLEASE INDICATE BELOW

TOTAL MONTHLY HOUSEHOLD INCOME FROM ALL SOURCES: \$ _____

TOTAL VALUE OF CHILD'S & PARENT(S) SAVINGS: _____

TOTAL VALUE OF CHILD'S & PARENT(S) INVESTMENTS: _____

PARENT OR GUARDIAN MUST SUBMIT A COPY OF LAST YEAR'S FEDERAL TAX RETURN (1040, 1040A, OR 1040EZ) WITH THIS APPLICATION

DOES THE CHILD RECEIVE MEDICAID BENEFITS? ____ YES ____ NO MEDICAID # _____

DOES THE CHILD HAVE DENTAL INSURANCE? ____ YES ____ NO

DENTAL NEEDS

BRIEFLY DESCRIBE THE CHILD'S DENTAL NEEDS: _____

DOES YOUR CHILD HAVE A DENTIST? _____

IF YES, NAME OF DENTIST: _____ PHONE#: _____

DATE OF LAST DENTAL VISIT: _____

HAS A DENTIST RECOMMENDED BRACES FOR YOUR CHILD? _____

HOW WILL YOU ENSURE YOUR CHILD GETS TO DENTAL APPOINTMENTS? _____

PLEASE LIST OTHER TOWNS YOU CAN GET TO: _____, _____,
_____, _____, _____

ADDITIONAL INFORMATION

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

Parent or guardian must be willing to adhere to Donated Orthodontic Services rules; the patient must:

- Have regular dental visits during the course of orthodontic treatment;
- Maintain good oral hygiene;
- Keep all regularly scheduled appointments
- Take proper care of all orthodontic appliances;
- Comply with all instructions given by orthodontist

I have read the above expectations and if applicant is selected to be a patient in the program, I will ensure that the conditions above are met.

Signature of parent or guardian: _____ Date: _____

(Please also sign the release on page 4)

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 condition.

I give my consent for the referral coordinator to obtain information from my child's physician, dentist, contact people I listed, and/or government or private agencies in order to determine their eligibility for the DOS program.

I understand information provided by me or others as noted above may be given only to the volunteers involved in my child's treatment and will be held confidential.

I give permission for the referral coordinator to share information about my child with one or more volunteer dentists in the DOS program.

I realize that the application to the DOS program does not assure my child will be referred for an examination or that they will be accepted as a patient following an examination.

I understand that the Foundation of Dentistry for the Handicapped, which coordinates the DOS program, will determine whether my child is eligible for the program and, if so, will seek to refer my child to a participating volunteer dentist. I further understand that the dentist, not the Foundation, is solely responsible for diagnosis and any possible treatment that my child might receive for their dental needs.

I understand that the dentist(s) have volunteered to treat my child's existing dental condition only and are not obligated to provide donated care in the future or to maintain my child as a patient.

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hour notice to the dentist, can and will disqualify my child 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, medical, and financial status.

Signature of parent or guardian: _____ Date: _____

Signature of person referring (if applicable): _____ Date: _____

Optional Photo and Information Consent Form

"I give permission to the Foundation of Dentistry for the Handicapped to use my child's 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 used in dental journals, website(s), media articles, advertisements or other marketing materials that promote the programs of the Foundation and encourage 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 the Foundation the right to copyright such material if necessary. **I understand that if I don't grant this permission, it will *not* affect my child's eligibility for receiving services through Donated Orthodontic Services (DOS).**"

Signature of parent or guardian: _____ Date: _____