HopeHealth Community VNA
10 Emory St., Attleboro, MA 02703

(774) 203-1326 Fax (401) 727-7070

Application for Participation in the Elder Dental Program

This form will be used to determine if you are financially eligible for the Elder Dental Program. The program does not provide free care—it connects you with a dentist who has agreed to provide your care, charging greatly reduced fees. These fees have been set by the program and are tied to your income level.

Applicant Information

Name: Phone Number:

Street Address:

Town: State: Zip Code:

Date of Birth: Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Preferred Pronouns (optional): ☐ she/her ☐ he/him ☐ they/them ☐ ze/zir

Marital status: ☐ Single/Divorced/Widowed ☐ Married

Race (Optional):
☐ White Non-Hispanic ☐ White Hispanic
☐ American Indian ☐ Asian
☐ Black or African American ☐ Native Hawaiian
☐ Other ☐ Two or more races
☐ Missing

Ethnicity (Optional): ☐ Hispanic ☐ Non-Hispanic

How did you hear about this program?

Do you have any physical limitations requiring a handicapped accessible dentist office?
☐ Yes ☐ No

Do you have any limitations regarding transportation to get to an appointment?
☐ Yes ☐ No

Are you on MassHealth? ☐ Yes ☐ No To learn more, call MassHealth at 1 (800) 841-2900

Are you a Veteran? ☐ Yes ☐ No ☐ Prefer not to answer

Oral Health Questions

1. Do you wear dentures? ☐ Yes ☐ No

2. When was your last cleaning?

3. Is anything hurting you now? ☐ Yes ☐ No
   If yes, explain:

4. Do you have any visible swelling in your mouth? ☐ Yes ☐ No
   If yes, explain:

5. Do you have any bleeding in your mouth or gums? ☐ Yes ☐ No
   If yes, explain:

6. Are any of your teeth loose? ☐ Yes ☐ No
   If yes, explain:

7. Do you have anything you'd specifically like a dentist to look at? ☐ Yes ☐ No
   If yes, explain:

8. Do you need pre-medication with antibiotics before dental work? ☐ Yes ☐ No

9. Do you currently have a dentist? ☐ Yes ☐ No
   If yes, please list dentist's name and town:

Financial Information

This section helps us figure out if you are eligible for the program. **You must include documentation regarding your Social Security income and a copy of your most recently filed federal tax return.**

INCOME

Please complete this section about other income (**before** taxes and deductions).
***If you are married, include your spouse's income*.**

Type of income	Amount received per year	Comments
Social Security		
Railroad Retirement		
Veterans' Benefits		
Retirement Funds		
Wages		
Pensions		
Alimony		
Other *Please specify:*		

RESOURCES

Resources usually include anything that can be turned into cash within 20 days.

Type of resource	Value	Comments
Checking account		
Savings account		
Certificates of Deposit (CDs)		
IRA		
Stocks		
Other		

Guidelines for Income Documentation

- ☐ Please do not send original documents, only photocopies.

- ☐ Please provide a copy of your most recently filed federal tax return.

- ☐ Please provide **one** of the following documents to verify your Social Security income:

    - Annual Benefit Statement (SSA -1099 form)
    - Annual award letter from the Social Security Administration
    - A benefit verification letter from the Social Security Administration detailing income received within the past 12 months.

- ☐ If you do not have one of these documents, you may request a benefit verification letter by calling Social Security at 1 (800) 772-1213, 7 a.m. – 7 p.m., Monday – Friday, or by contacting your local Social Security Administration Office.

- ☐ Additional documents may be requested to verify resources.

Assignment of Rights

Please read this section carefully and sign at the bottom.

I realize that the dental care offered by dentists in the Elder Dental Program includes diagnosis, fillings, cleanings, and other basic procedures. I will be referred to other providers such as dental schools or clinics for dentures and other similar restorative work. I understand the Elder Dental Program is a charitable endeavor and relies on grant funding and volunteers and is only able to accommodate patients based on available resources.

I understand that I have certain rights:

- I understand that I have the right to be treated with respect.
- I understand that my dental and medical information will be kept confidential.
- I understand that my financial information will be kept confidential.
- I understand that I will be told in advance of each dental appointment, how much I should expect to pay at the time of the dental appointments.
- I understand my protected health information will be shared between the dental provider(s) and the Elder Dental Program and will be done so in a manner that is in accordance with accepted privacy rules and practices.

I understand that I have certain responsibilities:

- I agree to keep appointments with my dentist. If I have to change an appointment, I will reschedule with 48 hours' notice.
- I agree to pay my dentist at the time of the appointment.
- I agree to cooperate with my dentist in developing a plan of care and to follow this plan and instructions, including having any X-rays recommended as necessary and appropriate. I understand that if I do not follow my dentist's recommendations, I may be discharged from care by my dentist and the Elder Dental Program.
- I agree to call the Elder Dental Program manager right away if I have any questions about my dentist appointment.

I have read and understand this information and agree with the rights and responsibilities.

_____ _____

Signature of Applicant Date

Mail or fax completed application to:
Elder Dental Program
HopeHealth Community VNA
10 Emory St.
Attleboro, MA 02703
Fax: (401) 727-7070

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