Eastern Oklahoma Donated Dental Services (E.O.D.D.S.)

Dental Applicant Information

E.O.D.D.S. operates on a first come, first serve bases; and you will not receive any notification that you have been approved for services until E.O.D.D.S. has reached your name on the appropriate dental-care waiting-list (based on the type of dental work you've applied for). We appreciate your patience and understanding through this process and ask that you only contact our office to update your personal information.

RESTORATIVE PROGRAM:

- Includes: Cleanings, fillings, root canals; crowns, extractions (the removal of teeth), repair work, etc.
- Qualifications: All applicants must be a low-income household without any other means of payment.
  - ☐ 65 years and older **OR**
  - ☐ Receiving a Social Security Administration Check (SS, SSI, SSD) **OR**
- Dental-Care list: Average waiting period is 3 years.

PROSTHETICS PROGRAM:

- Includes: Removable dentures and removable partials (No restorative work or extractions needed – See Restorative Program above if this work is needed)
- Qualifications: All applicants must be low-income household without any other means of payment.
  - ☐ 65 years and older **OR**
  - ☐ Receiving a Social Security Administration Check (SS, SSI, SSD) **OR**
  - ☐ Meets Federal Low-Income Household guidelines
- Dental-Care list: Average waiting period is 8 - 12 weeks.

Are you ready to mail your application in? Here is a check list for you.

☐ E.O.D.D.S. Patient Application (Page 2 – Completely filled-out with signature and date)

☐ E.O.D.D.S. Patient Responsibility Contract (Page 3 – Read, Sign and Date)

☐ Acknowledgement of Privacy Practices & Disclosure Form (Page 4 - Read, Sign and Date)

*Notice of Privacy Practices is on Page 5 and is for you to keep

☐ Proof of Income – Required with ALL applications – COPIES ONLY

- Social Security Benefit Verification letter for SS, SSI, and/or SSD
- Food stamp Award letter (if you do not receive Social Security)
- Most current Pay-stub (if you do not receive Social Security)

☐ To prove lack of income (no income), a formal letter from your case manager / social worker is required.

Please call E.O.D.D.S. with any questions (918) 742-5544

Read carefully, incomplete applications will be shredded.

E.O.D.D.S. Patient Application

*****APPLICATIONS ARE ACCEPTED THROUGH THE MAIL ONLY*****

Referring Agency/Organization: _____

Case Worker: _____ Ph#: _____

Applicant Information:

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ **State: OK** County: _____ Zip: _____

Main Phone #:_____ Secondary Phone #: _____

Male / Female Date of Birth: _____ Social Security #: _____-_____-_____

RACE: African American / Asian / Caucasian / Hispanic / Other / Native American: _____

Mental/Physical Health Problems: _____

_____

_____

Emergency Contact: _____ Ph. #: _____ Relation: _____

*An Emergency Contact is required for all applicants.

Total Household income: $_____ (Yearly / Monthly)

Sources of income (Circle those that apply **TO THE APPLICANT**): S.S. / S.S.I / S.S.D. / Other: _____

Total number of persons living in household: _____ (including applicant)

Other sources of Household Income: _____

Does your household receive Food stamps, housing and/or utility assistance? Y: ☐ N: ☐

**** PROOF OF INCOME IS REQUIRED WITH ALL APPLICATIONS****

DENTAL NEEDS: _____

_____

_____

_____

Do you need any teeth extracted (pulled)? Y: ☐ N: ☐ If YES, how many teeth need to be pulled? _____

Do you have Medicaid / Soonercare? Y: ☐ N: ☐ If YES, ID#: _____

Do you have other dental insurance? Y: ☐ N: ☐ If YES, Name of Insurance: _____

PATIENT RESPONSIBILITY CONTRACT

I. Should Eastern Oklahoma Donated Dental Services accept me as a recipient for free dental services, I agree that it is my responsibility to:

A. Obtain my own transportation to the dental appointments.

B. Arrive on time or early and not cancel or change any dental appointments, unless I have called and received permission from the E.O.D.D.S. staff.

C. Be courteous and cooperative with the volunteer dentists and staff always.

D. Follow directions of the dentists and staff while in treatment and once treatment is complete to preserve and maintain my dental health, including the practice of regular dental hygiene procedures and care of prosthetic appliances as indicated.

Patient Signature: _____ Date: _____

II. In signing this section of the Patient Responsibility Contract, I acknowledge that I am a low-income household without any savings accounts, CD's, Trust accounts, IRA's or any other means of paying for my dental needs and have provided proof of my income with this application.

Patient Signature: _____ Date: _____

III. I understand that I can be terminated from the E.O.D.D.S. program at any time if I have falsified any information on the application for services, or if I do not keep this agreement. E.O.D.D.S. reserves the right to terminate the contract between a client and E.O.D.D.S. at E.O.D.D.S.' discretion.

Patient Signature: _____ Date: _____

Please read the Patient Responsibility Contract and sign each section. A signature is required for each section before submitting your application to receive dental assistance.

PHOTO RELEASE

(Optional)

I hereby grant permission to E.O.D.D.S. to exhibit, publish, or distribute my image to be submitted displayed on their website www.EODDS.org, or their FACEBOOK page for promotional reasons.

I understand that the above uses may include but are not limited to videotapes, photographs, websites, multimedia programs, or other types of promotional medium existing now or in the future.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

and

AUTHORIZATION FOR ACCESS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, have received a copy of Eastern Oklahoma Donated Dental Services' (E.O.D.D.S.) Notice of Privacy Practices, and I hereby authorize the use or disclosure of my Protected Health Information to be provided to or obtained by E.O.D.D.S., a physician, dentist; a health care provide, social worker and/or case manager who will be providing treatment to me through E.O.D.D.S.

_____

Signature

(In effect so long as patient is a participant in any E.O.D.D.S. program)

_____

Date

☐ I did **NOT** receive a copy of the Privacy Practices; therefore I did not sign.

Availability and/or Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

WHEN COMPLETE, MAIL APPLICATION TO:

E.O.D.D.S.

9810 E. 42nd St. Ste. 210

Tulsa, OK 74146

*******PLEASE RETAIN THIS COPY FOR YOUR RECORDS*******

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in the volunteer dentists' facility and will not be misused or disclosed by/to anyone outside of E.O.D.D.S. and/or the volunteer dentist you will be assigned to. You may gain access to this information if you desire.
Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 14, 2003 and will remain effect.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our office and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment and healthcare providers. For example:

TREATMENT: We may use or disclose your health information to a physician, dentist, or healthcare provider who will be providing treatment to you through E.O.D.D.S.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioner/dentist and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

YOUR AUTHORIZATION

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member calling on your behalf, referral to volunteer dentist or specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS

We must disclose your health information to you as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.