West Virginia Department of HEALTH

ORAL HEALTH PROGRAM
Improving health, one smile at a time.

CLIENT APPLICATION FOR THE DENTURE PROJECT

THE DENTURE PROJECT
350 CAPITOL STREET, ROOM 427
CHARLESTON, WV 25301-3714
304-558-5388 OR 1-800-642-8522

DATE OF APPLICATION: _____

APPLICANT'S NAME: _____ PHONE: _____

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____ COUNTY: _____

DATE OF BIRTH: _____ AGE: _____ SEX: MALE ____ FEMALE ____

ALTERNATE CONTACT NAME: _____ RELATIONSHIP: _____ PHONE: _____

ARE YOU EMPLOYED? YES: ____ NO:____ IF YES, MONTHLY INDIVIDUAL WAGES: $_____

WHICH OF THE FOLLOWING DO YOU RECEIVE? (PLEASE SELECT ALL THAT APPLY):

- ☐ SUPPLEMENTAL SECURITY INCOME — MONTHLY AMOUNT: $ _____
- ☐ SOCIAL SECURITY DISABILITY INSURANCE — MONTHLY AMOUNT: $ _____
- ☐ SOCIAL SECURITY — MONTHLY AMOUNT: $ _____
- ☐ OTHER: _____ — MONTHLY AMOUNT: $ _____

PROOF OF INCOME IS REQUIRED

PLEASE NOTE: THE DENTURE PROJECT DOES NOT PROVIDE EXTRACTIONS OR RESTORATIVE SERVICES FOR EXISTING TEETH, ONLY THE FEES ASSOCIATED WITH DENTURES OR PARTIALS.

HAVE YOU BEEN TOLD BY A DENTIST THAT YOU NEED DENTURES OR PARTIALS? YES ____ NO ____
IF YES, APPROXIMATE DATE? _____

DO YOU REQUIRE ADDITIONAL DENTAL SERVICES (FILLINGS, EXTRACTIONS, ETC.)? YES ____ NO ____
IF YES, BRIEFLY DESCRIBE YOUR DENTAL NEEDS: _____

HAVE YOU PREVIOUSLY APPLIED FOR THIS PROGRAM? YES ____ NO ____
IF YES, APPROXIMATE DATE? _____

DO YOU HAVE DENTAL INSURANCE (OTHER THAN MEDICAID)? YES ____ NO ____

DO YOU RECEIVE MEDICAID BENEFITS? YES ____ NO ____

- Please note: if you have dental insurance or WV Medicaid, you must contact your insurance provider directly to verify your eligibility and benefits for dentures or partials. The Denture Project is the payor of last resort.

COMPLETE BACK

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Please read the following statements. If you understand and agree to the conditions, please sign, and date the form at the bottom.

I understand I will need to provide personal information that includes, but is not limited to, medical, dental, and financial conditions.

I give my consent for the referral coordinator to obtain information relevant to my eligibility for The Denture Project, from my physician, dentist, individuals who know me, and/or government or private agencies.

I give permission for the referral coordinator to share pertinent information about my eligibility with one or more volunteer dentist(s) in The Denture Project.

I understand that the application to The Denture Project does not assure I will be referred for an examination or that I will be accepted as a patient following an examination.

I understand the dentist, not The Denture Project, is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

I understand the dentist has volunteered to treat my existing dental condition only and is not obligated to provide donated care in the future or to maintain me 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, will disqualify me from obtaining further treatment through the program.

I understand that if I receive placement with a dental provider and fail to complete my treatment without good cause, I may not be approved through this program again.

I understand and agree with the above conditions. To the best of my knowledge, the information provided on this form is complete and accurate disclosure of my current financial status.

Applicant Signature: _____ Date: _____

Guardian Signature: _____ Date: _____