DOS Donated Orthodontic Services | AAOF American Association of Orthodontists Foundation

PATIENT APPLICATION

TO BE CONSIDERED FOR THE DONATED ORTHODONTIC SERVICES PROGRAM, PLEASE COMPLETE THE FOLLOWING:

☐ **DOS PATIENT APPLICATION**

COMPLETE THE ENCLOSED APPLICATION.

☐ **PARENTS OR GUARDIANS WILL NEED TO PROVIDE PROOF OF INCOME (FEDERAL TAX FORM 1040/1040EZ OR SSI AWARDS LETTER).**

PLEASE INCLUDE A COPY OF PROOF OF INCOME WITH YOUR APPLICATION. YOUR CHILD WILL NEED TO BE LISTED AS A DEPENDENT ON YOUR TAX RETURN.

☐ **PATIENT QUESTIONNAIRE**

HAVE YOUR CHILD COMPLETE THE "ABOUT YOUR CHILD" QUESTIONNAIRE (SEE LAST PAGE OF THIS PACKET) AND INCLUDE THE COMPLETED FORM WITH YOUR CHILD'S APPLICATION.

☐ **DENTIST REFERRAL FORM**

HAVE YOUR CHILD'S GENERAL DENTIST COMPLETE THE ENCLOSED DENTIST REFERRAL FORM. YOUR DENTIST'S OFFICE CAN RETURN THE FORM BY FAX.

MAIL APPLICATION TO:
AAO-DONATED ORTHODONTIC SERVICES PROGRAM
401 N. LINDBERGH BLVD.
ST. LOUIS, MO 63141

FAX: 314-689-0293

DUE TO HIGH DEMAND, APPLICATIONS WILL BE REVIEWED QUARTERLY. STATUS UPDATES WILL BE SENT OUT TO FAMILIES AS THE APPLICATIONS ARE PROCESSED.

QUESTIONS? 800-424-2841 X582

Patient Application

Donated Orthodontic Services

American Association of Orthodontists Foundation

Patient Information

Child's Name: **DOB:**

Child's Address:

City: **State:** **Zip:**

Child's Gender: ☐ Male ☐ Female ☐ Other_____

Child's Race and Ethnicity: *Select all that apply. Information collected will only be reported on a program scale and not connected to the individual recipient.*

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander
☐ White or Caucasian
☐ Multi-Racial/Multi-Ethnic
☐ Other_____

Where does your child reside?
By completing this form you represent that you have legal rights to make medical decisions for the child.

☐ Child lives with a parent or parents
☐ Child lives with a guardian/family member
☐ Child lives with a foster family/custody of the state

Parent/Guardian Information

Parent/Guardian #1 First, Last Name:

Relationship to Child:

Phone Number: **Email Address:**

Parent/Guardian #2 First, Last Name:

Relationship to Child:

Phone Number: **Email Address:**

List any adults (relatives or step-parents) below that can receive or obtain information regarding your child.
Include: Name, Relationship to Child, Phone Number, Email Address if applicable.

Foster Care/State Custody Information

Skip to next page if not applicable.

Contact First, Last Name: **Relationship to Child:**

Primary Phone Number: **Alternate Phone Number:**

Email Address:

Do you have legal documentation that allows you to make medical decisions for this child?
☐ Yes *Please attach a copy of the documentation.* ☐ No

List any adults (relatives, case managers, social workers) below that can receive or obtain information regarding this child. *Include: Name, Relationship to Child, Phone Number, Email Address if applicable.*

Orthodontic Needs Summary

Briefly describe your child's dental needs:

Does your child have a general dentist and/or has been seen recently in a dental clinic? *Your child will need to be seen by a denist before acceptance into the DOS program. Please contact your child's dentist to have them complete the Dentist Referral Form included in this application.*	□ Yes	□ No
Does your child have Medicaid benefits?	□ Yes	□ No
Does your child have private dental insurance?	□ Yes	□ No
Has your child been evaluated by an orthodontist? *If Yes, who did they see?*	□ Yes	□ No

Financial Information

Tax Returns or SSI Awards Letter

Parent or guardians must attach a copy of last year's federal tax return (1040/1040EZ) or Social Security (SSI) award letters for each household member with this application for review. Your child must be listed as a dependent in your household.

Household Members

List everyone living in the child's home (including parents and child requesting treatment). If more room is needed, attach another sheet.

Name	Age	Relationship to Child

Sources of Household Income

Please include monthly household income. If the category does not apply, just leave it blank.

Income Source	Household Member(s)	Total $ Amount
Monthly Wages/Employment		
Social Security (SSI/SSDI)		
Child Support		
Unemployment		
Temporary Assistance (TANF)		
Food Stamps		
Other		

Program Information

How did you hear about the DOS program?

How far will you travel for orthodontic treatment?
We will do our best to match you with a DOS provider close to your child's home.

- ☐ Less than 10 miles from the child's home
- ☐ 11-19 miles from the child's home
- ☐ 20-25 miles from the child's home
- ☐ More than 20 miles from the child's home
- ☐ Other:_____

Does your child have any special needs or medical concerns? If so, please explain.

Additional Information (share anything else you would like us to know)

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Donated Orthodontic Services Program Rules

Please read the following DOS Program Rules. If you understand and agree, enter your initials in the box next to each statement.

_____ 1. Donated Orthodontic Services (DOS) provides for orthodontic treatment only. Extractions, dental cleanings, oral surgery, periodontal therapy, and any other treatment that may be necessary before, during, or after orthodontic treatment are the financial responsibility of the patient's parents or legal guardians.

_____ 2. If your child has cavities or periodontal disease (gum disease), these conditions must be completely remedied before orthodontic treatment begins.

_____ 3. Your child must have a general dentist, who must verify that all necessary dental treatment has been completed before orthodontic treatment begins. In addition, your child must maintain regular dental appointments and cleanings during orthodontic treatment.

_____ 4. During treatment, if your child does not brush and floss properly, cavities can form around the braces. If your child does not maintain proper oral hygiene or if cavities form which are not remedied, the treating orthodontist has the option to remove the braces and end the orthodontic treatment. Your child may be dismissed from the DOS Program.

_____ 5. If your child is accepted into the DOS Program, orthodontic treatment will be provided by the assigned orthodontist only. If you move away from the treating orthodontist, the DOS Coordinator will attempt to find your child another treating orthodontist; however, DOS cannot guarantee that this will be possible. If you move before the orthodontic treatment finishes and DOS is unable to find a new orthodontist, you must advise your treating orthodontist and make any arrangements necessary to complete treatment, including finding a new orthodontist, which will become your financial responsibility, or having the current orthodontist remove the braces.

_____ 6. Regular orthodontic appointments are necessary to make sure the teeth move as expected and no unwanted movement occurs. Most of these appointments will be during school hours. It is your responsibility to make sure that all scheduled appointments are kept. Failure to maintain regularly scheduled appointments on a continued basis is grounds for the treating orthodontist to remove the braces and end the orthodontic treatment.

_____ 7. You and your child must completely follow the treatment plan recommended by your orthodontist. If you fail to follow the treatment plan, the treating orthodontist has the option to refuse to continue treatment, to remove the braces, and to end the orthodontic treatment.

_____ 8. During orthodontic treatment, your child must cooperate with the assigned orthodontist. Failure to cooperate fully with the orthodontist or to maintain proper behavior so that the treatment can be delivered can result in the orthodontist refusing to continue orthodontic treatment until the improper behavior is corrected or removing the braces and ending treatment.

_____ 9. Broken appliances or loose brackets and bands can cause damage to the teeth and the rest of the mouth. Your child must take special care not to eat hard or sticky foods or pull on the braces. If there is frequent damage to the braces, the treating orthodontist has the option of removing the braces or charging you to repair the damage, which is not covered by the DOS Program.

_____ 10. One retainer, which is necessary to keep the teeth from shifting, will be provided as part of orthodontic treatment at no charge. If the retainer is damaged or lost, you will be charged for a replacement retainer.

Donated Orthodontic Services Program Guidelines

Please read the following program guidelines. If you understand and agree to the conditions, please sign below.

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 program coordinator to obtain information from my child's physician, dentist, contact people I listed, and/or government or private agencies in order to determine 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 program coordinator to share information about my child with one or more volunteer Orthodontists 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 he or she will be accepted as a patient following an examination.

I understand that the American Association of Orthodontists (AAO), 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 orthodontist. I further understand that the orthodontist, not the AAO, is solely responsible for diagnosis and any possible dental treatment that my child might receive.

I understand that the orthodontist has volunteered to treat my child's existing dental condition only and is 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 orthodontists, can 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.

Parent/Guardian Print Name **Patient Name & Signature required if 18 years old.*	**Parent/Guardian Signature**	**Date**

Foster Parent/Custodian Print Name	**Foster Parent/Custodian Signature**	**Date**

Mail: AAOF Donated Orthodontic Services
401 N. Lindbergh Blvd, St. Louis, MO 63141
Fax: 314-689-0293
Questions: 800-424-2841 x582

Dentist Referral Form

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Dentist: Your patient has applied to receive Donated Orthodontic Services. Please complete the referral form on their behalf. Donated Orthodontic Services is a program of the American Association of Orthodontists Foundation (AAOF), with a goal of providing orthodontic treatment to children whose need is significant enough to suffer detrimental dental and/or social effects. Thank you for taking the time to thoughtfully consider your response.

Completed forms may be returned via secure fax to 314.689.0293.

Patient Name:	**DOB:**
How long has the patient been under your care?	
How often are they seen?	
Is the patient in <u>need</u> of orthodontic treatment? ☐ Yes ☐ No	
Is the patient motivated to receive orthodontic treatment? ☐ Yes ☐ No	
Does the patient's family keep appointments? ☐ Yes ☐ No	
Is the patient carries free? ☐ Yes ☐ No	
Does the patient have good oral hygiene? ☐ Yes ☐ No	

Description of patient's current condition:

Dentition	☐ Primary	☐ Mixed	☐ Permanent
Malocclusion	☐ Not Severe	☐ Moderate	☐ Severe
Spacing	☐ Yes ☐ No	Comments:	
Crowding	☐ Yes ☐ No	Comments:	
Overjet	☐ Yes ☐ No	Comments:	
Crossbite	☐ Yes ☐ No	Comments:	
Overbite	☐ Yes ☐ No	Comments:	
Misalignment	☐ Yes ☐ No	Comments:	

Would you recommend this patient for treatment through the DOS program? ☐ Yes ☐ No

Please include anything else that should be considered when evaluating this case:

Dentist Signature:	Office Contact Information:
Dentist Name (please print):	Date:

Thank you for your assistance! Questions: 1.800.424.2841 x582

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ABOUT YOUR CHILD

DOS APPLICATION QUESTIONNAIRE

PARENTS/GUARDIANS: PLEASE HAVE YOUR CHILD COMPLETE THE QUESTIONS BELOW. FOR MORE SPACE, FEEL FREE TO ATTACH ADDITIONAL PAGES.

CHILD'S NAME:

WHAT IS THE BEST PART ABOUT BEING YOUR AGE?

WHAT DO YOU WANT TO BE WHEN YOU GROW UP?

IF YOU COULD HAVE ANY SUPERPOWER, WHAT WOULD IT BE AND WHY?

YOUR FAVORITE THINGS

FOOD:

SONG:

COLOR:

HOBBY:

WHAT DO YOU LOVE MOST ABOUT YOURSELF?

TELL US ABOUT **YOU** IN **ONE** WORD:

ONE FUN FACT ABOUT YOU:

WHAT WOULD HAVING BRACES MEAN TO YOU?
HOW WOULD THEY MAKE YOUR LIFE BETTER?