Georgia Transplant Foundation

Enriching Lives Everyday

Dental Assistance Program
Patient Information Sheet

The Georgia Transplant Foundation developed a Dental Assistance Program to address the needs of patients attempting to be listed for an organ transplant. Chronically ill patients, often living on a fixed income, cannot afford extra dental costs, yet they must be cleared from a dental perspective to be eligible for transplant. Waiting times for organ transplants can span 2-5 years. GTF's dental assistance program's main focus is to expedite your dental care thus expediting your listing for transplant. This program is developed to help you restore your dental health in preparation for your transplant. Follow up care, including routine cleanings, will be your responsibility.

To access the GTF Dental Assistance Program, you must work with your social worker/coordinator either in your dialysis center or transplant center. You will need to receive a treatment plan from a dentist and complete the GTF financial assistance application. **Submit both documents to your social worker/coordinator for GTF review**. GTF will then contact the social worker to explain how we can help with your dental needs. **If approved, you will then make an appointment to begin your dental work**. You have 90 days to complete this dental work. Keeping appointments is extremely important. Please read the process listed below and give your dentist a copy of the "Provider Information Sheet" when you see him/her for your first visit.

Process:

1. If you are a **pre-transplant patient**, in order to be eligible for the Dental Assistance Program, dental needs must be the **FINAL** item required to be listed for transplant.
2. If you are a **post-transplant patient** their must be a serious health risk (such as a risk of infection) that is documented by your transplant center in order to be eligible for the Dental Assistance Program.
3. Patient will schedule an appointment with a dentist and obtain a plan of treatment. This appointment is at the patient's expense, GTF does not cover the cost of this visit.
4. Patient presents "Dental Provider Information Sheet" and fee schedule to dentist for review.
5. The dentist signs the agreement form, if willing to provide services at the documented fees. Dentist returns this form and the treatment plan to patient to attach with the application to GTF.
6. Patient completes GTF financial assistance application and submits to social worker/coordinator with signed agreement from dentist and treatment plan for dental needs.
7. **GTF reviews the application and notifies the requesting social worker of decision. GTF must approve your dental work before you begin treatment or you will be responsible for the cost.**
8. GTF faxes letter to dentist outlining the amounts agreed upon for payment.
9. Requesting social worker/coordinator notifies patient who schedules appointment with dentist.
10. Approval is good for 90 days and only services listed on the original treatment plan are covered.
11. Upon completion of all treatment, dental provider will fax bill to GTF office for payment of previously agreed amount.
12. GTF will pay the invoice within 10 business days.
13. Patient notifies the transplant center of the completion of dental work.

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GTF has developed a fee schedule of covered procedures. We are asking you to review this schedule and consider providing dental services to this client based on the attached fee schedule and reimbursement process. As GTF supports members of the transplant community in receiving quality affordable dental care, we ask that each service provider agree to charge the lower amount of either your routine fee or the fees on the attached schedule.

Responsibilities of the dentist are as follows:

1. The **patient is responsible** for the cost of their initial visit with you.
2. Review the attached fee schedule.
3. If in agreement to accept payment from GTF at fee schedule pricing, sign attached agreement and **give to patient** to submit with GTF request for payment.
4. **Provide patient** with a written treatment plan for all dental care needed.
5. If GTF approves the patient's application, GTF will fax dentist an approval letter for payment.
6. Dentist can then schedule client for dental treatment, which should be completed within 90 days.
7. Dental office will fax GTF a bill when **ALL treatment** is completed.
8. GTF will pay invoice to dentist according to previously agreed fee schedule within 10 business days.
9. No "add-on" treatment or follow up treatment will be covered by GTF.
10. **No treatment will be paid without prior approval by GTF.**
11. Future dental needs are the responsibility of the client and there is NO further responsibility from GTF.

Thank you for working with this client and the Georgia Transplant Foundation to meet the dental requirements of patients who need to be listed for a transplant. If you have any questions please feel free to contact Alicia Wood, Assistant Director of Patient Services at 770-457-3796.

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Provider Agreement Form

I have read the Provider Information Sheet and understand my responsibilities. I have reviewed the attached fee schedule and agree to provide services to the following transplant candidate/recipient ____ for the amount listed on the treatment plan and in accordance to the GTF fee schedule or my routine cost, which ever cost is less.
I understand that the Dental Assistance Program's purpose is to expedite transplant readiness and will work to complete the dental procedures needed within 90 days, if possible. **I also understand that no treatment will be paid without prior approval by GTF.**

____
Signature

____
Fax

____
Name
____
Address
____
City State Zip code
____
Phone Fax
____
Billing Manager - to handle billing and payment

Give this signed form and treatment plan **to the patient** to submit to their transplant social worker/coordinator who will then send to GTF along with their application.

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2009 Dental Fee Schedule

PROCEDURE	**FEE**	**PROCEDURE**	**FEE**
Examinations		**Endodontics (Root Canal)**	
Initial Oral Examination	Pt Pays	Single Canal	$500
		Two Canals	$600
X-Rays		Three Canals	$650
Full Mouth	$80		
		Crowns	
Preventive		Crowns are covered only on molar teeth	$600
Prophylaxis - Adult cleaning	$60	with a current root canal	
Debridement (full mouth)	$170	Core build up	$90
Periodontal Scaling and Root (per quad)	$175		
		Prosthodontics	
Restorations / Fillings		Complete Upper Denture	$650
Amalgam - One Surface	$70	Complete Lower Denture	$650
Amalgam - Two Surfaces	$90	Upper Partial Denture	$650
Amgalgam - Three Surfaces	$100	Lower Partial Denture	$650
Amalgam - Four + Surfaces	$115		
Resin - One Surface	$85	**Other Services**	
Resin - Two Surfaces	$110	General Anesthesia - first 30 minutes	$200
Resin - Three Surfaces	$120	General Anesthesia - each additional 15 min	$50
Resin - Four + Surfaces	$130	IV Sedation - first 30 minutes	$195
		IV Sedations - each additional 15 minutes	$80
Oral Surgery		Oral Sedation – single tooth extraction	$35
Single Tooth Extraction	$95	Oral Sedation – multiple tooth extraction	$150
Additional Tooth Extraction	$65		
Surgical Extraction of Tooth	$160		
Gingivectomy (per quad)	$275		
Alveoplasty (per quad)	$150		
Alveoplasty (less than a quad)	$55		

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Providing this information will not adversely affect any consideration you may receive for GTF services.

CLIENT INFORMATION:

____
First Name Middle Last Name

____
Street Address Apt/ Suite Number

____
City State Zip Code County

______________ ______________ ______________
Home Phone Cell Phone E-mail Address

_____Male _____Female Marital Status ____________ Spouse's Name ____________________________________

__________ ______ ______________ ______________ ______________
Date of Birth Age Social Security Number Number in Household Number of Children (living in household)

DEMOGRAPHIC INFORMATION:

______________________ ______________ ______________
Transplant Center Date of Transplant Organ

____
Follow-up Care

Race Optional (Please Check): _____ Hispanic _____ African American _____Black _____ White, Non-Hispanic _____ Asian-American _____Asian-Pacific Islander _____Native American _____ Other

Level of Education Optional (Please Check): _____GED, _____ attended High School (number of years____), _____ High School Graduate, _____ Technical Certificate / Diploma, College (number of years_____), _____ Associates, _____ Bachelors, _____ Masters, _____PhD

Current Source of Income: (Please check all that apply) _____ Full time employment _____ with benefits _____ Part-time employment _____ with benefits, _____ Retirement pension, _____Working spouse, _____ Parent Income, _____ Social Security Retirement, _____ Social Security Disability (SSDI), _____ Supplemental Security Income (SSI)

Work Status (Please check): _____Currently employed, Employer Name ______________________________
_____Medically Disabled ____________________ (Date), _____Retired, _____ Unemployed ____________________ (Date)

Current Source of Healthcare Coverage:(Please check all that apply) ____Insurance ____ Spouse's Insurance

____ Parent's Insurance ____Medicare ____Medicaid ____QMB Medicaid ____ Spend-down Medicaid ____ COBRA

Check all that apply:

☐ Recipient ☐ Candidate ☐ Living donor ☐ JumpStart Client ☐ Wellness Conference Attendee

☐Workshop attendee ☐ Mentor with Mentor Project ☐ GTF Volunteer/Board Member/Committee Member

How did you hear about GTF Services? GTF Website/Newsletter/Brochure _________________________
GTF Staff…Name __________________________ GTF Volunteer, Name________________________________
Transplant Center Staff, Name ___________________________________

2009 FINANCIAL ASSISTANCE APPLICATION

DO NOT LEAVE ANY FIELD BLANK

ASSETS

ACCOUNTS:
CHECKING $ ____________________
SAVINGS $ ____________________

AUTOMOBILES:
YEAR__________ YEAR __________
MAKE__________ MAKE __________

Household: All people living in your home (includes all children, adult or minor), non-related household members, parents, grandchildren, siblings, renters, etc.
Income: Total amount for wages or salary income, self-employment income, interest, dividends and rental income, Social Security Retirement and Social Security Disability Income, Supplemental Security Income, child support, public assistance, TANF, food stamps, family's financial help, income from working children, parents, siblings etc who reside in your household.
Expenses: General household expenses per month - rent/mortgage, food, average utilities, phone charges – basic phone, cell phone, credit card payments – monthly amount, not total balances owed.

MONTHLY HOUSEHOLD NET INCOME	
WAGES (net)	$__________
SOC.SEC.(SSDI, SSI)	$__________
ADDITIONAL DISABILITY	$__________
PENSION	$__________
SPOUSE'S INCOME	$__________
FAMILY MEMBER'S INCOME	$__________
TANF	$__________
VETERAN'S PENSION	$__________
RENTAL INCOME	$__________
RETIREMENT INCOME	$__________
DIVIDENDS	$__________
OTHER (SPECIFY)	$__________
____________________	$__________
____________________	$__________
TOTAL MONTHLY INCOME	$__________

MONTHLY HOUSEHOLD EXPENSES	
RENT* ☐ MORTGAGE* ☐	$__________
FOOD	$__________
UTILITIES	$__________
TELEPHONE	$__________
GAS & ELECTRICITY	$__________
CELL PHONE	$__________
WATER	$__________
TRANSPORTATION	$__________
AUTO PAYMENT	$__________
GASOLINE	$__________
MEDICAL EXPENSES	$__________
DOCTORS FEES	$__________
HOSPITAL PAYMENTS	$__________
MEDICATIONS	$__________
DENTAL	$__________
INSURANCE	$__________
MEDICAL	$__________
LIFE	$__________
AUTO	$__________
CHARGE ACCOUNTS	$__________
BANK CARDS (monthly payment)	$__________
BANK CARDS (monthly payment)	$__________
DEPARTMENT STORES	$__________
OTHER______________	$__________
TOTAL MONTHLY EXPENSES*	$__________

I authorize information released between the GTF and my transplant center or other related parties to verify information related to this request. I agree to be added to GTF database for future mailings.

______________________________ ______________

APPLICANT'S SIGNATURE DATE

*If you are not paying rent or mortgage, please explain: ____

____

**If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month: ______________

____

Patient's Name ____

Check(s) Payable to: (List name of payee and attach supporting documents)

1.____ AMT$_______________

2.____ AMT$_______________

3.____ AMT$_______________

TOTAL AMOUNT REQUESTED: $________________

Social Worker's/Coordinator's Statement:
(Please document fully the background information creating the need and your recommendations)

____

____

____

____

____

____

____

____

____

____

____

____

____

Is it appropriate to refer this individual to JumpStart? ___________________

Requesting Social Worker/Coordinator______________________________ Date__________________

Center Name ______________________ Phone___________________ Pager _________________

- Checks will be made payable to the companies stated above and mailed to the applicant, unless stated otherwise.
- Please remember to complete the appropriate authorization forms, if needed for your request and include supporting documentation.