

DENTAL ASSISTANCE APPLICATION

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



CLIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

Mailing Address _____ Apartment/Unit# _____

City _____ State _____ Zip Code _____ County _____

Home Phone _____ Cell Phone _____ E-mail _____

Male Female Marital Status _____ Spouse's Name (if applicable) _____

Date of Birth _____ / _____ / _____ Age _____ Social Security Number _____

Total # of People Living in Household _____ # Adults in Household _____ # Children in Household _____

Date of Transplant (if applicable) _____ / _____ / _____ Organ _____ Transplant Center _____

DEMOGRAPHIC INFORMATION

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 (# of years _____) High School Graduate
 Technical Certificate/Diploma Currently Enrolled in College Attended College (# of years _____)
 Associates Degree Bachelors Degree Post-Graduate Degree Other _____

Work Status (please check) Currently Employed; Employer Name _____
 Medically Disabled _____ Date _____ Retired Unemployed _____ Date _____

Current Source of Income (please check all that apply) Full-Time Employment with benefits Working Spouse
 Part-Time Employment with benefits Parent(s) Income Retirement Pension
 Social Security Retirement Social Security Disability (SSDI) Supplemental Security Income (SSI)

Current Source of Healthcare Coverage (please check all that apply)
 Insurance (please circle: BCBS; United Healthcare; Humana; Kaiser; Aetna; Other _____) Spouse's Insurance
 Medicare Medicaid QMB Medicaid Spend-down Medicaid COBRA

Check all that apply to you: Recipient Candidate Living Donor JumpStart Client
 Trends In Transplant (TNT) Conference Attendee Fundraising Workshop Attendee
 Mentor/Mentee GTF Volunteer/ Board Member/ Committee Member

How did you hear about GTF services? GTF Website/ IMPRINT Magazine/ Brochure GTF Staff, Name _____
 GTF Volunteer, Name _____ Transplant Center Staff, Name _____

Patient's Name _____

PLEASE ANSWER ALL QUESTIONS FOR THE REVIEW COMMITTEE

PART THREE - FINANCIAL INFORMATION

DO NOT LEAVE ANY FIELD BLANK

ASSETS:

CHECKING	\$ _____
SAVINGS	\$ _____
STOCKS & BONDS	\$ _____
RETIREMENT ACCOUNTS	\$ _____

AUTOMOBILE(S):

YEAR _____	YEAR _____
MAKE _____	MAKE _____

Household: All people living in your home (includes all children or adults), non-related household members, parents, grandchildren, siblings, renters, etc.

Income: Total amount for wages or salary income, self-employment income, interests, 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

(please read above description)

WAGES (net)	\$ _____
SPOUSE'S INCOME	\$ _____
FAMILY MEMBER'S INCOME	\$ _____
SOCIAL SECURITY (SSDI, SSI)	\$ _____
ADDITIONAL DISABILITY	\$ _____
PENSION	\$ _____
RETIREMENT INCOME	\$ _____
VETERAN'S PENSION	\$ _____
TANF	\$ _____
FOOD STAMPS	\$ _____
RENTAL	\$ _____
DIVIDENDS	_____
OTHER	\$ _____
_____	\$ _____
TOTAL MONTHLY INCOME	\$ _____

MONTHLY HOUSEHOLD EXPENSES

(please read above description)

RENT* <input type="checkbox"/>	MORTGAGE* <input type="checkbox"/>	\$ _____
FOOD		\$ _____
UTILITIES		_____
TELEPHONE		\$ _____
GAS & ELECTRICITY		\$ _____
CELL PHONE		\$ _____
WATER		\$ _____
TRANSPORTATION		_____
PUBLIC TRANSPORTATION		\$ _____
AUTO PAYMENT		\$ _____
GASOLINE		\$ _____
MEDICAL EXPENSES		_____
DOCTORS FEES		\$ _____
HOSPITAL PAYMENTS		\$ _____
MEDICATIONS		\$ _____
DENTAL		\$ _____
INSURANCE		_____
MEDICAL		\$ _____
LIFE		\$ _____
AUTO		\$ _____
CHARGE ACCOUNTS		_____
BANK CARDS (monthly payment)		\$ _____
OTHER _____		\$ _____
OTHER _____		\$ _____
TOTAL MONTHLY EXPENSES**		\$ _____

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

APPLICANT'S SIGNATURE _____ DATE _____

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

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



Georgia Transplant Foundation

Enriching Lives Everyday

Dental Assistance Program Provider Information Sheet

The Georgia Transplant Foundation (GTF) 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 dental care, thus expediting a patient's listing for transplant. In order to receive dental clearance for transplant, a patient needs to be **clear of infection. Thus the goal of any dental work provided by GTF is to clear infection, not necessarily to complete a full scope of potential dental needs.**

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 our fee schedule pricing, please sign attached agreement and **give to the patient** to submit with their GTF request.
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 **approved 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 Rebekah Moshiri, Program Manager of Patient Services at 770-457-3796.



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. In order to receive dental clearance for transplant, a patient needs to be **clear of infection. Thus the goal of any dental work provided by GTF is to clear infection, not necessarily to complete a full scope of potential dental needs.** Follow-up care, including routine dental cleanings will be your responsibility.

To access the GTF Dental Assistance Program, you must work with your social worker 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 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 below and give your dentist a copy of the "Provider Information Sheet" when you see them for your first visit.

Process:

1. If you are a **pre-transplant patient**, in order to be eligible for the Dental Assistance Program, dental clearance must be the **FINAL** item required to be listed for transplant.
2. If you are a **post-transplant patient**, there 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. The dentist returns this form and the treatment plan to the patient to attach with the application to GTF.
6. Patient completes GTF financial assistance application and submits to transplant 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/coordinator 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. Approval is good for 90 days and only services listed on the original treatment plan are covered.
10. Upon completion of all treatment, dental provider will fax bill to GTF office for payment of agreed amount. GTF will pay the invoice within 10 business days.
11. Patient notifies the transplant center of the completion of dental work.



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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

Email

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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DENTAL FEE SCHEDULE

PROCEDURE	FEE	PROCEDURE	FEE
Examinations		Endodontic (Root Canal)	
Initial Oral Examination	Pt Pays	Single Canal	\$500
		Two Canals	\$600
X-Rays		Three Canals	\$650
Full Mouth	\$80		
Preventive		Crowns	
Prophylaxis - Adult cleaning	\$60	Crowns are covered only on molar teeth	\$600
Debridement (full mouth)	\$170	with a current root canal	
Periodontal Scaling and Root (per quad)	\$175	Core build up	\$90
		Prostodontics	
Restorations / Fillings		Complete Upper Denture	\$650
Amalgam - One Surface	\$70	Complete Lower Denture	\$650
Amalgam - Two Surfaces	\$90	Upper Partial Denture	\$650
Amalgam - Three Surfaces	\$100	Lower Partial Denture	\$650
Amalgam - Four + Surfaces	\$115		
		Other Services	
Resin - One Surface	\$85	General Anesthesia - first 30 minutes	\$200
Resin - Two Surfaces	\$110	General Anesthesia - each additional 15 min	\$50
Resin - Three Surfaces	\$120	IV Sedation - first 30 minutes	\$195
Resin - Four + Surfaces	\$130	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		