Donated Orthodontic Services (DOS) • Illinois

Program Guidelines and Application Process

Donated Orthodontic Services (DOS) is a once in a lifetime opportunity that utilizes a network of orthodontists who volunteer their time and resources to care for children whose family could not otherwise afford their child's necessary orthodontic treatment. DOS works to provide children and families with another, more obtainable option for braces so they may have a new, straighter smile.

QUALIFICATIONS FOR ELIGIBILITY

Your child must meet **ALL** of the following areas to apply for the program:

i. Be between the ages of 11 and 18 when they begin treatment and reside in Illinois
ii. Not currently be in active orthodontic treatment (*i.e.* – not wearing braces),
iii. Have a current general dentist and good oral hygiene,
iv. Have a total household income at or below the 200% of federal poverty level
v. Have no other resources or means through which they can receive orthodontic treatment, and…
vi. Be able to pay the **non-refundable $200 fee** upon acceptance into the program

APPLICATION PROCESS

1. A completed application must be signed and returned to the DOS coordinator **along with all of the following items:**
    - Last year's federal tax return for the household or Social Security awards letter
    - Completed dentist referral form (enclosed) to be completed by child's regular dentist
    - Letter from the child explaining why he/she wants the braces and how he/she intends to care for them.

Please note: Incomplete applications, or applications missing the required additional items, will be returned and a new application will have to be submitted to be considered for the DOS program.

2. Once the application is received it will be reviewed and will be placed on the waiting list ***IF*** your child pre-qualifies. All applicants will receive written notice of their application status, whether it pre-qualifies or has been denied.

The amount of time an application is placed on a wait list varies by location and available volunteers; the wait time can be up to 18 months in some areas.

3. Once your child's application reaches the top of the wait-list you will be contacted by the DOS coordinator and an intake will be completed. During this time your child's eligibility for the program will be confirmed or denied.

4. **Upon your child acceptance into the DOS program you will have 14 days to submit the non-refundable $200 program fee.** If the fee is not received within 14 days your child's case will be closed and you will need to re-apply to be considered for the program again. Unfortunately at this time we cannot take payments from Flexible Spending Accounts or Health Savings Accounts. Additionally, we can only receive payments in full as partial payments will not be accepted.

Please Note: This program fee helps to ensure the sustainability of the DOS program and all the effort that goes into ensuring your child receives the necessary orthodontic care at no cost to you.

5. Upon receiving the program fee the DOS coordinator will refer your child to one of our volunteer orthodontists. ***This process can take at least six weeks*** as our volunteers' availability varies greatly, thereby dictating whether they will agree to see your child immediately or not.

Application for Donated Orthodontic Services (DOS) Program

Donated Orthodontic Services
1800 15th Street, Suite 100
Denver, CO 80202
(866) 201-5906
(303) 534-5290 - Fax

For Internal Use Only:	Requested	Received
Tax/ Income Verification:	☐	☐
Dentist Referral Form:	☐	☐
Letter from Child:	☐	☐

Applicant

Child's Name:_____ Date of Application: _____

Parent or Guardian's Name: _____ Phone:_____

Address:_____

City, State, Zip: _____ County:_____

Child's Date of birth: _____ Age: _____

Circle: Male Female

Email Address: _____

Preferred Form of Communication (Circle One):
Phone Email Mail

How did you hear about the DOS program? _____

Contact person (relative, friend, etc.):

Name: _____ Phone: _____

Relationship to child: _____

Number of people in child's household: _____

Name of each person	Age	Relationship to child

Financial Information

Household Monthly Income:

Parent or Guardian #1_____ Are you employed? ___Yes ___NO

Place of Employment: _____

Your monthly wages: $_____

Parent or Guardian #2_____ Are you employed? ___Yes ___NO

Place of Employment: _____

Your monthly wages: $_____

Are there any other sources of income for your household, such as social security, SSI, Tanf, unemployment, child support, etc.? If so, please indicate below:

_____

_____

_____

TOTAL MONTHLY HOUSEHOLD INCOME FROM ALL SOURCES: $_____

Total value of child's & parent(s)

savings:_____

_____

Total value of child's & parent(s)

investments:_____

_____

_____

*****Parent or guardian must submit a copy of last year's federal tax return or SSI awards letter with this application.*****

Does the child receive Medicaid benefits? ____yes ____no Medicaid # _____

Does the child have dental insurance? ____yes ____no

Dental Needs

Briefly Describe Child's Dental Needs:

_____

_____

Does your child have a dentist? □ Yes □ No If yes, Name of dentist: _____

Date of last dental visit:_____ Phone#_____

Has a dentist recommended braces for your child? _____

Do any other members of your family have braces, receive orthodontic care, or received care in the past?

□ Yes □ No If so, when? _____

How will you ensure your child gets to dental appointments? _____

_____

Please list other towns you can get to:_____

Additional Information

_____

_____

Use this space to elaborate on any information not sufficiently explained in other areas.

_____

_____

_____

Parent or guardian must be willing to adhere to Donated Orthodontic Services rules; the patient must:

- Have regular dental visits during the course of orthodontic treatment;
- Maintain good oral hygiene;
- Keep all regularly scheduled appointments
- Take proper care of all orthodontic appliances;
- Comply with all instructions given by orthodontist

To the best of my knowledge, the information included in this application is a full and accurate account of the applicant's current medical, physical and financial status. Additionally, I have read the above expectations and if applicant is selected to be a patient in the program, I will ensure that the conditions above are met.

_____ _____ _____

Signature of parent or guardian Date

_____ _____

Signature of patient *(if 18 or older and own guardian)* Date

Please also sign the release on page 8

Terms and Conditions (required page)

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

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

I understand that Dental Lifeline Network, 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 Dental Lifeline Network, is solely responsible for diagnosis and any possible treatment that my child might receive for their dental needs.

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

_____ _____ _____

Signature of parent or guardian Date

_____ _____

Signature of patient *(if 18 or older and own guardian)* Date

Photo and Information Consent Form

(Optional)

"I give permission to Dental Lifeline Network to use my child's name, information, statements, or photograph for public relations purposes, and to attribute my statements to me as an expression of my personal experience. I understand that this information may be used in dental journals, website(s), media articles, advertisements or other marketing materials that promote the programs of Dental Lifeline Network and encourage involvement from dental professionals and funders. I also agree that no material needs to be submitted to me for any further approval, and I give Dental Lifeline Network the right to copyright such material if necessary.

I understand that if I don't grant this permission, it will *not* affect my child's eligibility for receiving services through Donated Orthodontic Services (DOS)."

_____ _____

Signature of parent or guardian Date

_____ _____

Signature of patient *(if 18 or older and own guardian)* Date

Program Patient Rules (required page)

1. Donated Orthodontic Services (DOS) provides orthodontic (braces) treatment only. Other treatments, such as extractions, dental cleanings, oral surgery, periodontal therapy, etc., may be necessary before, during, or after orthodontic treatment. These are the financial responsibility of the child's parents or legal guardians. This treatment may be sought through public aid as well.

2. Your child must be in good oral health before starting orthodontic treatment. Problems such as cavities, gum disease, etc., must be taken care of.

3. Your child must have and is currently seeing a general dentist. They must verify your child is in good oral health before orthodontic treatment begins. Also, your child must keep regular dental appointments and cleanings during orthodontic treatment.

4. If your child does not maintain proper oral hygiene or if cavities form and are not taken care of the treating orthodontist has the option to end the orthodontic treatment. This means your child's braces would be removed early. Then your child will be dismissed from the DOS Program.

5. If your child is accepted into the DOS Program, treatment will be provided by the assigned volunteer **only**. If you move away before braces are removed the DOS Coordinator will attempt to find your child another volunteer orthodontist. DOS cannot guarantee this will be possible. You will then have to advise your current orthodontist and make any needed arrangements to finish treatment. This may include removing the braces early, finding a new orthodontist. or paying for services yourself.

6. All appointments need to be kept. Be prepared, many appointments will be during school hours. These appointments are necessary to make sure the teeth move appropriately. Failure to do so is reason for you child's removal from the program and your child's braces would then be removed.

7. You and your child must follow the orthodontist's treatment plan. This plan will be explained to you before treatment begins. If you fail to follow the treatment plan, the treating orthodontist may remove your child's braces and end all treatment.

8. Your child must behave appropriately at appointments. Failure to do so would mean your child could be removed from the program. Braces would be removed and all treatment would stop.

9. Your child must take special care of their braces. No hard or sticky foods and never pull on the braces. If there is frequent damage to the braces your child may be removed from the program or you will have to pay to fix them. Damaged braces or loose brackets and bands can cause damage to your child's teeth and mouth.

10. One retainer 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. Retainers are necessary to keep the teeth from shifting so take special care of them.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of patient *(if 18 or older and own guardian)* Date

Dear Dentist: **Date: _____**

Please complete the following orthodontic referral for the Donated Orthodontic Services (DOS) program.

Dentist Name: _____ Phone Number: _____

Patient Name: _____ Date of Birth: ______________

Date of Last Appointment: _____________ How often are they seen in your office: _____

Is Patient in need of orthodontic treatment? ☐ Y ☐ N

Description of current condition:

Malocclusion:	☐ Class I	☐ Class II	☐ Class III
Spacing:	☐ Mild ≤ 3mm	☐ Moderate 4-6mm	☐ Severe ≥ 7mm
Crowding:	☐ Mild ≤ 3mm	☐ Moderate 4-6mm	☐ Severe ≥ 7mm
Overjet:	☐ Normal	☐ Moderate 2-5mm	☐ Severe ≥ 6mm
Crossbite:	☐ None	☐ Anterior	☐ Posterior

Overbite:	☐ Normal	☐ Moderate (50-75%)	☐ Severe (> 75%)	☐ Open Bite
Misalignment:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Description of Dentition: ☐ Primary ☐ Mixed ☐ Permanent

Does Patient have good oral hygiene? ☐ Y ☐ N

Caries free? ☐ Y ☐ N

Does the family keep appointments? ☐ Y ☐ N

Is the child motivated to receive orthodontic treatment? _____

Comments:

_____ ______________

Signature Date

Printed Name