DENTAL ASSISTANCE APPLICATION

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

Georgia Transplant Foundation
Enriching Lives Everyday

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 childrenor 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	**$**

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**

MONTHLY HOUSEHOLD EXPENSES

(please read above description)

RENT* ☐ MORTGAGE* ☐	$
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**	**$**

*** 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:**

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:

(Pease 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.**
- **Please verify that the address and financial information is current and complete.**

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Dental Assistance Program
Patient Information Sheet

The Georgia Transplant Foundation (GTF) offers the Dental Assistance Program to address the needs of pre-transplant patients working to get listed for an organ transplant and post-transplant patients who have significant sources of infection. 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 cleanings, will be your responsibility.

Eligibility:

1. Pre-transplant patients – your transplant center is requiring dental clearance as the FINAL item required to be listed for transplant.

2. Post-transplant patients – your transplant center has documented a serious health risk (such as risk of infection) due to needed dental treatment.

How to Apply:

1. Contact your dialysis or transplant center social worker to discuss the need. Verify with your social worker that your dental needs and transplant center requirements fit within the eligibility guidelines.

2. Schedule an appointment with a dentist. This appointment is at the your (the patient's) expense. GTF does not cover the cost of this visit.

3. Explain your needs and the assistance program to your dentist. Give your dentist the "Dental Provider Information Sheet" and fee schedule for review.

4. If your dentist agrees to the terms of the program, ask the dentist to sign the Provider Agreement Form and return it to you along with a treatment plan.

5. Complete the GTF Financial Assistance Application in its entirety and submit to your social worker, along with the Provider Agreement Form and treatment plan from your dentist. **Do not schedule dental work until your application is processed and approved by GTF or you will be responsible for payment.**

Process:

1. Your social worker will submit your application to GTF. GTF will review the application and notify your social worker of decision.

2. GTF will notify your dentist of the approval and amount agreed upon for payment. Approval is good for 90 days for the services listed in the treatment plan. Be sure to make and keep your dental appointments in order to get the work completed within 90 days.

3. Upon completion of all treatment, your dental provider will fax the bill to GTF for payment of previously agreed amount. GTF will issue payment directly to dental office within 10 business days.

4. Patient should notify their social worker and/or transplant center of the completion of dental work.

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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.

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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		
		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
Amalgam - 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		