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 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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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		