FUNDY DENTAL
COMMUNITY
PROJECT

Patient Application Form

7322 Highway 1
Coldbrook, NS B4R 1B9

fundydental.com/community

☎ 902-681-9111 902-681-9115 fundycommunity@bellaliant.com

FUNDY DENTAL COMMUNITY PROJECT

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Local Dentists Helping Patients in need gain control of their dental health

The Fundy Dental Community Project (FDCP) is a pilot program initiated by local dentists to provide basic dental services to motivated, low-income youth and adults to complete a treatment plan aimed at treating their current dental disease. This program was developed to establish a healthy oral condition in qualified patients, and provide them with the education necessary to maintain their improved oral health status.

Applicants must meet all of the personal, financial and dental need criteria for acceptance into the FDC program. There are, however, a limited number of applicants that can be accepted into the program at a particular time. For appropriate care the FDCP can only accept 100 applications at a time before new applicants will be considered. The intention is to process these 100 applicants every 3-4 months.

The three basic criteria to accept patients into the FDCP program include:

1. **Personal.** A complete application form and personal statement must be submitted with all the necessary detail and supplemental information included
2. **Financial Considerations**. Applicants must submit information from CRA NOAs that confirm true financial constraints that prevent appropriate preventative dental services
    - Federal Low income levels are used as a cut-off for treatment in the FDC Program:
        - 1 person – $16,750
        - 2 persons – $20,000
        - 3 persons – $25,000
        - 4 persons – $30,000
        - 5 persons – $35,000
        - 6+ persons – $40,000
3. **Dental Needs**. Applicants must have significant dental disease that has a negative impact on their general health or employment status. Significant dental disease to confirm eligibility in the FDC program includes any of the following:
    - 8 or more teeth affected (multiple restorations required – anterior or posterior)
    - Multiple extractions necessary (5+ teeth removed, based on cavities or gum disease)
    - Missing or fractured anterior teeth that pose a barrier to employment

Applicants will be notified within two weeks of submission whether or not they qualify for the FDC program or not. If unsuccessful, applicants will be informed of the reason. A patient that does not qualify has the option of filing an appeal with the Fundy Dental Community Association (FDCA) Board of Directors. The process of appeal with the FDCA board will be considered at each quarterly meeting.

Limitations of the Fundy Dental Community Program:

- Treatment in FDCP is not free of charge, but rather patients must pay a nominal fee based on a rate per hour, which is different than a traditional fee-for-service model
- Not all persons that cannot afford preventative dental care will be eligible for this program
- All basic dental services are included, however, major dental services and certain treatment options may not be available through the FDCP program

We welcome any questions you may have about the application process. For assistance, or inquiries, please contact the office,

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Part 1 - PERSONAL INFORMATION

Birth date: _____ Health Card No._____

Name: _____ Address: _____

Town: _____Prov: _____ Postal Code: _____ email: _____

Occupation: _____Employer: _____

Home Phone:_____Work Phone:_____

Parent / Guardian (if under 18) or Next of Kin:_____Phone:_____

Marital Status: _____# of Family Members (adults & dependents): _____

Family Doctor:_____ Town:_____

Do you qualify for government assistance with dental care? Yes / No Social Assistance, NIHB, Veteran's Affairs

Do you have Private Dental Insurance? Yes / No Can we send claims electronically for you? Yes / No

Please provide details of your insurance plan to our receptionist, and if there is secondary coverage through a spouse

DENTAL HISTORY

What is your major dental complaint? _____

Do you have a regular dentist? Yes / No Name: _____ Town: _____

Do you seek regular preventative dental care? Yes / No Last Dental Visit Date: _____

Have you had issues with dental treatment in the past? please explain _____

Do visits to the dentist make you nervous? (circle one) Not at all / Somewhat / Moderate / Very / Extremely

How did you hear about this office? Location / Website / Yellow Pages / Facebook / Twitter / Radio Ads

Please circle one option Friend / Dentist / Doctor / ER / Social Services / FDC Program / Other

MEDICAL HISTORY

Are you in good health? Yes / No

Have you had a physical exam in the past 6 months? Yes / No Do you smoke? Yes/ No How long? _____

Do you drink more than 10 alcoholic beverages per week? Yes / No

Do you have any allergies? Please list: _____

Are you taking any medications? Please list or provide a copy: _____

_____

_____

Are there medical conditions that you are being treated for at this time? _____

_____

Do you have a history of, or present issue with, any of the following? Abnormal Heart Condition □ Diabetes □ Heart Attack □ Prolonged Bleeding or Disorder □ Asthma □ Breathing Issue □ Liver/Kidney Disease □ Cancer / Tumor □ High Blood Pressure □ Migraines □ Hives □ Stroke □ Psychiatric Treatment □ Major Injury □ STD/HIV/AIDS □ Drug Abuse □

Other □ _____

Are any of the above uncontrolled or require further information? _____

To the best of my knowledge, all preceding answers are true and correct. Please inform your dentist of any change in health or medications. Also, please review our **Privacy and Consent Statement** in the waiting area.

Signed: _____

Date: _____

Office Only

HR: _____ Exam: _____

BP: _____ X-ray: _____

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Part 2 - FINANCIAL INFORMATION FORM

Please provide the Net Income for the applicant in each of the 2 most recent years, as well as any significant other (spouse, partner, common law), or that of all parents and guardians of any applicant twenty-two (22) yrs of age or younger. This information is shown on the Canada Revenue Agency (CRA) Notice of Assessment (NOA) form – **Please provide one copy of 'Page 2' of each NOA form and attach to this application form or provide to the FDCP staff processing the application**.

Please be advised that this information will remain confidential and will only be used by the FDCP staff and Board of Directors to evaluate the financial need of the family**.** The working sheet below is provided as a template for applicants to determine if they may be eligible for treatment under the FDCP financial restrictions. This page does not have to be submitted with the applications (NOAs alone will suffice).

PATIENT /Parent/Guardian #1

Taxable Income from last year (Line 260) _____

Minus: Total Tax Payable from last year (Line 435) _____

Equals: After Tax Income from last year: _____

Taxable Income from prior year (Line 260) _____

Minus: Total Tax Payable from prior year (Line 435) _____

Equals: After Tax Income from prior year: _____

Parent/Spouse/Guardian #2

Taxable Income from last year (Line 260) _____

Minus: Total Tax Payable from last year (Line 435) _____

Equals: After Tax Income from last year: _____

Taxable Income from prior year (Line 260) _____

Minus: Total Tax Payable from prior year (Line 435) _____

Equals: After Tax Income from prior year: _____

Parent/Guardian/Significant Other #3

Taxable Income from last year (Line 260) _____

Minus: Total Tax Payable from last year (Line 435) _____

Equals: After Tax Income from last year: _____

Taxable Income from prior year (Line 260) _____

Minus: Total Tax Payable from prior year (Line 435) _____

Equals: After Tax Income from prior year: _____

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Part 3 - Personal Statement Form

This section must be **completed by the applicant**

Please let us know why you are applying to the "Fundy Dental Community Project"

- How has your dental health negatively affected your life?
- What are you hoping to achieve by restoring your oral health?

Signed: _____ Date: _____

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Part 4 - Personal Reference Form

We require a personal reference from someone who knows the applicant well. Any adult non-relative can act as a personal reference. This might be a colleague, co-worker, community or religious leader. A relative/guardian of the applicant cannot provide a personal reference.

Please give a copy of this page and the next to the person providing the personal reference. It provides a brief outline of the "Fundy Dental Community Project" and the expectations of the personal reference.

"Fundy Dental Community Project" (FDCP) is a pilot program initiated by local dentists to provide basic dental services to motivated, low-income youth and adults on a one-time basis to treat their dental disease. This program has been developed to establish a healthy oral condition in qualified patients, who would otherwise not receive treatment, and provide them with the education necessary to maintain their improved oral health status. Dental treatment is provided by participating dentists who have offered to donate their services to this worthwhile program. We are asking for your input to help us determine if the applicant has the appropriate desire and eligibility for this program.

Your personal information should include the following (or complete the subsequent page attached):

1. Name of the applicant
2. Your name
3. Your position/occupation
4. Your address
5. Your phone number
6. Your e-mail address
7. Your relationship to the applicant
8. How long you have known the applicant
9. The way(s) you think the applicant is affected by his/her teeth and smile
10. Your description of the applicant's desire
11. Whether you would recommend the applicant for treatment through FDCP

Please limit the personal reference to one page. You should sign the personal reference, seal it in an envelope, sign it again over the seal of the envelope and return it to the applicant for submission to the program.

Thank you for your help with this application. If you have any questions about the program or the personal reference, please visit www.fundydental.com/community or contact us by e-mail at: fundycommunity@bellaliant.com

Part 4 - Personal Reference Form

Applicant Name: _____

Reference Name: _____

Address: _____

Town: _____ Prov: _____ Postal Code: _____

email: _____ Home/ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Relationship to the Applicant: _____

How Long Have you know the applicant? _____ yrs

What ways do you think the applicant has been affected by his/her teeth (dental health)?

_____

_____

_____

_____

_____

Please provide a description of the applicant's nature or desire to improve their oral health:

_____

_____

_____

_____

_____

Do you recommend the applicant for treatment in this program at this time? YES / NO (please circle)

Signed: _____ Date: _____

Please seal this reference in an envelope, sign it again over the seal of the envelope and return it to the applicant for submission to the program.

Thank you for your help with this application. If you have any questions about the program or the personal reference, please visit www.fundydental.com/Community or contact us by e-mail at: FundyCommunity@bellaliant.com

Part 5 – Program Rules, Expectations & Release Form

Program Rules, Treatment Expectations - Applicants must read and agree to the following to be accepted into the FDCP program

Applicants. Applicants agree to provide accurate information to the best of their ability (personal, medical, dental and financial data). There are no age limits to apply for treatment in the FDCP Program other than patients must be over 15 yrs old (patients younger than this should have preventative and basic dental care performed at a general dentist office under the current MSI dental program with GSC).	
Appointments. The applicant acknowledges that many other patients are waiting for treatment in the limited FDCP appointment times, and as such all scheduled appointments must be respected. It is mandatory for patients to be present for a scheduled appointment in this program - applicants may be dismissed from the program if they do not comply. A courtesy reminder call will be given in advance of the appointment time, but patients are responsible to keep all scheduled appointments even if they cannot be reached by FDCP staff the day before. Rescheduling an appointment is allowed if 48 hrs notice is given.	
Patient Payment. Once applicants are qualified they will be contacted about the balance they will be responsible for at each appointment. Payment for each appointment is received by FDCP at the time of scheduling, and may not be reimbursed if the patient does not show for their scheduled appointment without appropriate notice.	
Treatment Plan. The applicant acknowledges the scope of treatment provided by the FDCP program. Other treatment options may be discussed, even if they cannot be provided under the constraints of this program. Successful applicants have one year to complete the proposed treatment (based on the date of the initial examination and radiographs), otherwise their status in the program will expire and will be reconsidered only upon re-application, under special circumstances.	
Treatment Restrictions. Dental disease and necessary treatment is an ongoing phenomenon. Subsequent treatment needs related to work completed in the FDCP program are not eligible once patients have been dismissed from the program.	
One-Time Program Acceptance. This program is meant to relieve patients from pain and help them gain control of their dental disease. There is no recall aspect or long term treatment planning with the current scope of the FDCP program. Patients that have successfully completed their treatment with FDCP are encouraged to find a dentist in their area and have regular preventative dental services in a general practice setting.	

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Emergencies. The Fundy Dental Walk-in Clinic is run as a separate entity to the FDCP program. Patients that have yet to be formally qualified for the FDCP program are treated in the same manner as the general population in the Emergency Clinic. If a successful applicant has a dental emergency while awaiting their scheduled appointment, they are able to have the single emergency treatment completed under their FDCP eligible category. Qualified applicants cannot use the Walk-in Emergency clinic model to have their FDCP approved treatment plan completed, these appointments have specific scheduled times.

Hygiene. *All applicants must have at least one hygiene appointment*. This includes a discussion to help the patient understand the factors that lead to their current situation. Dental disease is preventative, and the proper education and tools will be provided so patients can reduce their risk of progression of dental disease in the future. Patients acknowledge the above statement, agree to disclose appropriate personal and social factors that have contributed to their current state of dental health, and will actively work to avoid preventable dental disease in the future (ie nutritional changes and improve oral hygiene habits).

Non-compliance. Patients that do not comply with a basic level of personal oral hygiene may be disqualified from this program. Any inappropriate behaviour or abusive language toward health care providers or staff can disqualify an applicant from this program. Patients will not receive reimbursement of funds if they are disqualified from the FDCP Program (application fee and/or scheduled appointment deposits).

Records. Applicants consent to supplementary photography, filming, x-rays, and additional professional staff observing the procedure as deemed appropriate. Any clinical records taken in this FDCP Program and specific case details may be included in future patient presentations and media content, provided the identity of the patient is not revealed.

Questionnaire. Patients are to complete a post-treatment questionnaire upon request.

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