



Dear Applicant:

In response to your recent inquiry about the availability of free or low-cost Orthodontic care, we are pleased to provide the following information about the Donated Orthodontic Services (DOS) program in the State of New Jersey.

Orthodontists throughout New Jersey have volunteered to provide Orthodontic care to children, who because of lack of adequate family income, cannot afford needed orthodontic care.

The following are eligibility criteria for the program:

ELIGIBILITY

- Patients must be a resident of New Jersey
- Patients must be between the ages of 7-18; adults will be considered under special circumstances only
- Patients cannot already be in braces or in between phases of orthodontic treatment.
- Parent or guardian must submit their most recent federal (and state if applicable) tax returns with their application.
- Patient must be ineligible for orthodontic treatment through insurance or public aid.

APPLICATION PROCEDURES

- STEP ONE: Please complete, sign and return the enclosed application, along with a copy of the last year's 1040, 1040A or 1040EZ tax return for the household.
- STEP TWO: When your application comes up for review, a referral coordinator will call to obtain any additional required information (those who do not qualify will be told so during the call)
- STEP THREE: The referral coordinator will share the information about a person tentatively accepted with a volunteer Orthodontist.
- STEP FOUR: You will be notified of the orthodontist's name and phone number and you will be responsible for scheduling an appointment for an examination. FINAL ACCEPTANCE into the program will only be made after the clinical examination when the specific treatment needs are established.

Upon receipt, your application will be placed on a waiting list. Please be patient; due to program limitations, we are not able to process each application as soon as it is received. The referral coordinator will contact you when the application comes up for review.

Teresa Lioudakis, Referral Coordinator NJ DOS
25 Kennedy Blvd., Suite 400, E. Brunswick, NJ 08816
732-296-6718 or 877-720-55579 Fax: 732-296-6719 email :tlioudakis@nfdh.org



APPLICATION FOR NJAO DONATED ORTHODONTIC SERVICES (DOS) PROGRAM

Send to: _____ DATE OF APPLICATION: _____

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APPLICANT

Child's Name: _____

Parent or Guardian's Name _____ Phone: _____

Address: _____ Please Circle: Male Female

City, State, Zip: _____ County: _____

Child's Date of Birth: _____ Age: _____

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:\$ _____



FINANCIAL INFORMATION CONTINUED

Are there any other sources of income for your household, such as social security, SSI, TANF, Unemployment, Child Support, etc.)? _____

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 TAXRETURN (1040), 1040A, or 1040EZ) WITH THIS APPLICATION

DOES THE CHILD RECEIVE MEDICAID BENEFITS? _____ YES _____ NO

MEDICAID # _____

DOES THE CHILD HAVE DENTAL INSURANCE? _____ YES _____ NO

DENTAL NEEDS

BRIEFLY DESCRIBE THE CHILD'S ORTHODONTIC NEEDS: _____

DOES YOUR CHILD HAVE A DENTIST? _____ YES _____ NO

IF YES, NAME OF DENTIST: _____ PHONE: _____

DATE OF LAST DENTAL VISIT? _____

HAS A DENTIST RECOMMENDED BRACES FOR YOUR CHILD? _____ YES _____ NO

HOW WILL YOU ENSURE YOUR CHILD GETS TO ORTHODONTIC APPOINTMENTS ON TIME?



IS THERE AN ORTHODONTIST THAT PARTICIPATES IN THE DOS PROGRAM THAT HAS ALREADY AGREED TO TREAT YOUR CHILD? _____YES _____NO

IF YES, NAME OF ORTHODONTIST: _____ PHONE: _____

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 the Orthodontist

I HAVE READ THE FOLLOWING RULES AND IF APPLICANT IS SELECTED TO BE A PATIENT IN THE DOS PROGRAM, I WILL ENSURE THAT THE CONDITIONS ABOVE ARE MET.

SIGNATURE OF PARENT OR GUARDIAN: _____

DATE: _____

(PLEASE ALSO SIGN THE RELEASE ON PAGE 4)



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 in 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 / orthodontists 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 the National Foundation of Dentistry for the Handicapped, 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 treating orthodontist is solely responsible for diagnosis and any possible treatment that my child might receive for their orthodontic needs.

I understand that the National Foundation of Dentistry for the Handicapped, the New Jersey Association of Orthodontists (NJAO), and the American Association of Orthodontists (AAO) cannot be held liable for any orthodontic and/or dental treatment rendered by referral through this service.

I understand that the orthodontist(s) have volunteered to treat my child’s existing orthodontic 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. Repeated failure to do so, without at least 24 hours notice to the orthodontist, may disqualify my child from obtaining further treatment through this 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 Person Referring (if applicable): _____ DATE: _____

Optional Photo and Information Consent Form

“I give permission to the National Foundation of Dentistry for the Handicapped, the NJAO, and the AAO 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), medical articles, advertisements or other marketing materials that promote the programs of the Foundation 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 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: _____