AMERICAN ACADEMY OF IMPLANT DENTISTRY FOUNDATION

211 East Chicago Avenue, Suite 1100
Chicago, IL 60611
312-335-1550

Wish a Smile

In response to your recent inquiry about the availability of free or low-cost implants, we are pleased to provide the following information about the Wish a Smile Program. Dentists throughout the country have volunteered to provide implants to low income patients who have no other access to implant dentistry.

Eligibility

- Patients must be one of the following:

  a.) 17 years or older and have congenitally missing 1-3 teeth and financially disadvantaged OR

  b.) Disabled veteran who are financially disadvantaged patients, age 17 and older with 1-3 missing teeth OR

  c.) Disabled veteran who are financially disadvantaged 17 and older, who are edentulous or have terminal dentition to receive a 2-implant overdenture solution

- Patients cannot be in the midst of an implant with another dentist when applying for the program.
- Patients must be receiving regular dental care and have good oral hygiene.
- Patients must have no financial means to pay for dental care.
- Patient must be ineligible for treatment through insurance or public aid.
- Patients will receive a maximum of three (3) implants. Patient does not require any soft or hard tissue augmentation to accommodate a dental implant (however, qualified volunteer can provide soft or hard tissue augmentation treatment on his/her own and outside this program)

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Application Procedures

Step One: **Please complete, sign and return the enclosed application, along with a copy of the items below:**

- **Last year's federal tax return for the household or Social Security award letter.**
- **DD-214 Letter (if a veteran)**

All information MUST be included in order for an application to be considered.

Step Two: You will then be placed on our waiting list.

Step Three: 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 Four: The referral coordinator will share the information about the patient who is tentatively accepted with a volunteer dentist.

Step Five: You will be notified of the dentist'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 initial clinical examination when the specific treatment needs are established.

***Upon receipt of your completed application, the applicant 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 your application comes up for review.

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Application for Wish a Smile Program

Wish a Smile
1800 15th Street, Suite 100
Denver, CO 80202
Phone # 877-827-1284
(303) 534-5290 - Fax

Date of Application: _____

Applicant:

Applicant's Name:_____ Phone:_____

Address:_____

Please Circle: Male Female

City, State, Zip:_____ County:_____

Date of birth: _____ Age: _____

Email Address: _____

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

How did you hear about the program? _____

Contact person (relative, friend, etc.):

Name: _____ Phone: _____

Relationship: _____

Number of people in household: _____

Name of each person	Age	Relationship to applicant

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

FINANCIAL INFORMATION

Household Monthly Income:

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 savings:_____

Total value of investments:_____

A copy of last year's federal tax return or SSI awards letter must be submitted with this application.

Do you have dental insurance? ____Yes ____No

Dental Needs:

Briefly describe the need for an implant:_____

Do you have a dentist? ____Yes ____No

If yes, Name of dentist: _____ Phone#_____

Date of last dental visit:_____

How will you get to your 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.

_____

_____

_____

Patient must be willing to adhere to Wish a Smile rules.

The patient must:

- Maintain good oral hygiene
- Keep all regularly scheduled appointments
- Take proper care of the implant
- Comply with all instructions given by the dentist

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:_____

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 situation.

I give my consent for the referral coordinator to obtain information from my physician, dentist, contact people I listed, and/or government or private agencies in order to determine their eligibility for the Wish a Smile program.

I understand information provided by me or others as noted above may be given only to the volunteers involved in my treatment and will be held confidential.

I give permission for the referral coordinator to share information about me with one or more volunteer dentists in the Wish a Smile program.

I realize that the application to the Wish a Smile program does not assure I will be referred for an examination or that I will be accepted as a patient following an examination.

I understand that Dental Lifeline Network, which coordinates the Wish a Smile program, will determine whether I am eligible for the program and, if so, will seek to refer me to a participating volunteer dentist. I further understand that the dentist, **not Dental Lifeline Network or the AAID Foundation**, is solely responsible for diagnosis and any possible treatment that my child might receive for their dental needs.

I understand that the dentist has volunteered to treat my existing dental condition only and are not obligated to provide donated care in the future or to maintain me 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 me 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 applicant: _____ Date: _____

Signature of person referring (if applicable): _____ Date: _____

Optional Photo and Information Consent Form

I give permission to Dental Lifeline Network to use my 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 eligibility for receiving services through the Wish a Smile Program.

Signature of applicant: _____ Date: _____