CCD SMILES

www.CCDsmiles.org
935 S Orem Blvd.
Orem, UT 84058

Patient Assistance Application

PATIENT INFORMATION

How did you hear about CCD Smiles?

Does the patient have any familial or business relationship with any Director or Officer of CCD Smiles? [ ] yes [ ] no

NAME: First M.I. Last

GENDER: [ ] Male [ ] Female	**DATE OF BIRTH:**	**AGE:**
PHONE:	**ALTERNATE PHONE:**	**EMAIL ADDRESS:**

MARITAL STATUS:
[ ] Married [ ] Single [ ] Divorced [ ] Other:

ADDRESS:
Street City State Zip Code Country

PARENT/LEGAL GUARDIAN NAME:
First Last

RELATIONSHIP TO PATIENT:
[ ] Mother [ ] Father [ ] Legal guardian [ ] Self [ ] Other:

Is this the first time you have submitted an application to CCD Smiles?
[ ] yes [ ] no (If no, please explain)

Name of patient's HEALTH INSURANCE provider:

Person who carries this plan:

Relationship to patient:

Name of patient's DENTAL INSURANCE provider:

Person who carries this plan:

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Relationship to patient:

Please enter a brief description of the medical history of the patient (medical conditions, previous surgeries, etc):

At what age were you diagnosed with Cleidocranial dysplasia (CCD)? _____
Who diagnosed you with CCD? _____

Describe what CCD Smiles money will be used for:

Does the patient's health insurance plan cover some of the cost? [ ] yes [ ] no (Please explain)

Has the patient sought assistance to help with the dental procedure/service you are requesting from other public or private sources? [ ] yes [ ] no (Please explain)

What is the estimated out of pocket cost, after insurance, in whole dollars? $ _____

Is there any other information you would like to provide?

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FINANCIAL INFORMATION

Number of people living in household: _____

Household Assets:

Cash (checking, savings, safe deposit box, mattress):	**$**
Investments (401k, IRAs, other):	**$**
Monthly Gross Pay:	**$**
Monthly Child Support Income:	**$**
Monthly SSI, Food Stamps, etc.:	**$**
Monthly other:	**$**

Is there any other financial information you would like CCD Smiles to consider?

Acknowledgments/Waiver:

By submitting this application, applicant agrees to the following terms and conditions:

1. Applicant shall cooperate with proposed treatment plan outlined by healthcare professional.
2. Applicant shall sign all necessary documents to allow CCD Smiles to comply with HIPAA laws.
3. Applicant understands and acknowledges that CCD Smiles does not guarantee approval of application.
4. CCD Smiles reserves the right to change the terms and conditions of all CCD Smile grants at any time without notice.
5. CCD Smiles will make every effort to respond to applicant's application within 90 days from date of receipt.

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After all documents are completed, you have read the acknowledgements/waiver and signed below, submit:

[ ] Patient application

[ ] Health care provider form

[ ] Copy of most recent filed federal income tax return

[ ] Current Form W-2

[ ] Current paystubs

[ ] Copy of medical insurance card (front and back)

[ ] Copy of dental insurance card (front and back)

By mail: CCD Smiles 935 S. Orem Blvd. Orem, UT 84058

By email: info@ccdsmiles.org

CCD Smiles will provide you an email confirmation upon receipt of your application.

NOTE: Be sure to keep a copy for your records for reference.

Incomplete applications will not be considered.

Applicant's Statement:

As the applicant of a CCD Smiles grant I am agreeing to the acknowledgments/waiver related to CCD Smiles policies, and state the information contained within the application is, to the best of my knowledge, true and accurate.

Signature: _____ Date: _____

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Health Care Provider Form

Health care provider name: First: Last: Degree: Credentials/specialty:
Phone number:
Email address:
Office Address:
PATIENT INFORMATION
Patient's Name: First: Last:
Patient's date of birth:
Diagnosis/Condition(s):
Relevant Medical History Statement:
Proposed Treatment Plan:

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Proposed start date:
Estimated length of treatment:
Estimated cost of treatment: $
Do you anticipate the patient's health and/or dental insurance plan covering any of the costs of treatment? (Please explain):
From your knowledge of the patient and their circumstances, does this patient need financial assistance in order to complete the proposed treatment plan?
Other comments:

Health Care Provider's Statement:

As a provider I am properly credentialed to provide the proposed treatment plan detailed above. I am in good standing with my licensing board(s). I am willing to work with CCD Smiles to

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facilitate delivery of the proposed treatment plan. I am stating the information contained within the application is, to the best of my knowledge, true and accurate.

Signature: _____ Date: _____