CATHOLIC CHARITIES
Save A Smile
Upstate Region

Have you received assistance from Catholic Charities before: Yes ☐ No ☐
Is anyone in your household working? ☐ Yes ☐ No

How did you learn about Save A Smile?

CLIENT INFORMATION

NAME: **SSN (last 4 only):** **DATE:**

ADDRESS: **CITY:**

STATE: **ZIP:** **COUNTY:**

PHONE: (**)** **ALTERNATE PHONE: (** **)**

General Information:

Date of birth: / /

Age (in years):

Sex: ☐ Male ☐ Female

Client Category (check any that apply):

- ❑ Veteran
- ❑ Unemployed
- ❑ Disabled
- ❑ Receives Medicaid
- ❑ Receives Medicare

Ethnicity:

- ❑ Caucasian
- ❑ African-American
- ❑ Hispanic
- ❑ Native American
- ❑ Asian
- ❑ Other:

Marital Status:

- ❑ Married
- ❑ Separated
- ❑ Single
- ❑ Divorced
- ❑ Widow(er)

Housing:

- ❑ Rent
- ❑ Own
- ❑ Public Housing
- ❑ Section 8
- ❑ Homeless
- ❑ Temporarily Living with Friend or Relative
- ❑ Other:

Total Household Members: ○1-2 ○3-4 ○5-6 ○7-8 ○9+

Number of Adults:
Number of Children (<18):
Number of Seniors:

CLIENT HOUSEHOLD INFORMATION

Name	Date of Birth	Ethnicity	Relationship

CLIENT HOUSEHOLD INFORMATION

Name	Date of Birth	Ethnicity	Relationship

MONTHLY INCOME/EXPENSE INFORMATION

MONTHLY INCOME		MONTHLY EXPENSES	
EMPLOYMENT	$	CAR PAYMENT	$
SPOUSE EMPLOYMENT	$	GASOLINE	$
SSI/DISABILITY	$	INSURANCE (CAR-LIFE)	$
SSI/DISABIITY (CHILD)	$	HOUSING/RENT (RENT-MORTGAGE-LOT RENT)	$
SOCIAL SECURITY/RETIREMENT	$	UTILITIES (LIGHTS-WATER-PROPANE)	$
SNAP	$	CELL PHONE	$
FI	$	CHILD CARE/AFTER SCHOOL CARE	$
CHILD SUPPORT	$	FOOD/SNAP	$
OTHER	$	MEDICAL EXPENSES	$
INCOME TOTAL	$	MISC. HOUSEHOLD	$
		TOTAL EXPENSES	$

INCOME TOTAL:$
EXPENSE TOTAL:$
BALANCE:$

I certify that the information entered above is true to the best of my knowledge. Catholic Charities is authorized to verify this information.

Client's Name in Print **Client's Signature** **Date**

Authorization for Client Participation in Media Relations Efforts

I _____, **(Client's name)**

am willing to have my picture(s) taken, video recorded and/or my voice recorded and grant Catholic Charities of South Carolina, The Diocese of Charleston, and other agencies participating in this event, to use my picture, my voice and physical surroundings without restriction for the purpose of Save A Smile, be it print, projection, internet website, video or any future media markets.

I give my permission for Catholic Charities of South Carolina or representatives or any institution transmitting or exhibiting my picture or voice from any claims arising from such use or distribution.

I agree to be fully responsible for my own participation and hold Catholic Charities of South Carolina or representatives harmless from any liability, loss of expense arising from the use of my picture or voice. I also consent to the use of my name, my voice and/or picture, and other material about me from promotional, publicity, or organizational purposes.

Client's Name Printed: _____

Client's Signature: _____

Today's Date: _____

Receiving Staff Name Printed: _____

Receiving Staff Signature: _____

Intake Date: _____

UPSTATE CATHOLIC CHARITIES

MEMORANDUM OF UNDERSTANDING

"SAVE A SMILE" – DENTURE PROGRAM

This statement defines and outlines the process for providing assistance to clients in obtaining:

- Full Set of Upper and Lower Economy Denture
- Full Upper Economy Denture
- Full Lower Economy Denture
- Partial Economy Denture

PROGRAM COMPONENTS:

- Client is responsible for attending and keeping all appointments. **Clients that do not show for their appointment will be required to pay any applied no-show fee.**
- Client is responsible for contacting Upstate Catholic Charities for a follow-up and feedback upon receiving new dentures from dental clinic.
- Upstate Catholic Charities will make payment to referred Dental Office as per our mutual agreement.
- Client understands that Upstate Catholic Charities is not responsible for payment of any additional services that you request which may include:
  - Soft and/or Hard Relines
  - Adjustments
  - Crowns
  - Implants
- Client is responsible for communicating with Upstate Catholic Charities if any concerns arise.

EFFECTIVE DATE/DURATION:

This agreement is effective on the date of signature by all parties indicated below and shall be effective for **only thirty (30) days.**

SIGNATURES/ACCEPTANCE BY:

_____ Date _____

Client

_____Date_____

Authorized Catholic Charities Staff Member

Required Documents

Along with this form, please email the following documents:

- Photo ID
- Proof of Monthly Income
- Proof of a Monthly Expense
- Proof of Insurance (If Applicable)

Please send all forms to Silvia Loaiza via email:

sloaiza@charlestondiocese.org