



# CATHOLIC CHARITIES

## Save A Smile Coastal Office

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/DISABILITY (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





# Save a Smile Program Agreement

This statement defines and outlines the process for helping clients obtaining services from North Charleston Dental Outreach (denture provider) and Catholic Charities (guarantor).  
**Client initials are required and indicate client reviewed and understands the program guidelines.**

**Program Guidelines:**

- Client is responsible for arriving to all appointments on time.
- Client is responsible for attending and/or rescheduling all appointments.
- Client is responsible for attending all appointments with CCC Case Manager
- Client is responsible for communicating with CCC staff member with any issues.
- Client understands that CCC is only providing payment for denture services as outlined per agreement with NCDO.

**Services include:**

Economy Dentures (basic)

- Full set dentures
- Full upper or full lower dentures
- Upper or lower partial denture

Client understands that CCC is not responsible for payment of any additional services that are required and/or requested which may include:

- Full mouth X-Rays	-Extraction(s)
- Soft and/or Hard Relines	- Adjustments
- Crowns	- Implants

Client is responsible for his/her portion of the payment and the client agrees to pay this amount directly to North Charleston Dental Outreach.

Client understands that this agreement is effective on the date of signature and is only effective for 30 days.

If the client requires more than 30 days for services to be provided, the client must contact CCC Case Manager immediately for further discussion.

**Client's Name Printed:** \_\_\_\_\_

**Client's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Receiving Staff Name Printed: \_\_\_\_\_

Receiving Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## **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 Molly Heisler via email:**

**[mheisler@charelstondiocese.org](mailto:mheisler@charelstondiocese.org)**