



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: () _____

<p><u>General Information:</u></p> <p>Date of birth: ____ / ____ / ____</p> <p>Age (in years): _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><u>Client Category (check any that apply):</u></p> <p><input type="checkbox"/> Veteran <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Receives Medicaid <input type="checkbox"/> Receives Medicare</p>	<p><u>Ethnicity:</u></p> <p><input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____</p> <p><u>Marital Status:</u></p> <p><input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)</p>	<p><u>Housing:</u></p> <p><input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Public Housing <input type="checkbox"/> Section 8 <input type="checkbox"/> Homeless <input type="checkbox"/> Temporarily Living with Friend or Relative <input type="checkbox"/> Other: _____</p> <p>Total Household Members: 1-2 3-4 5-6 7-8 9+</p> <p>Number of Adults: _____ Number of Children (<18): _____ Number of Seniors: _____</p>
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CLIENT HOUSEHOLD INFORMATION

<u>Name</u>	<u>Date of Birth</u>	<u>Ethnicity</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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



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@charelstondiocese.org