CATHOLIC CHARITIES
Save A Smile
Pee Dee 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

Completed forms must be sent to anaramore@charlestondiocese.org

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**

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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: _____

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Release to Obtain and Disclose Information

Client's Name: _____

By signing below, I am authorizing Catholic Charities to obtain my dental records of care from the provider(s) listed below:

❑ **Primary Dentist** (Name, Address, City, State, Zip Code, Phone Number)

_____

_____

❑ Sexton Dental Myrtle Beach/Florence Location:
Office: (843) 449-0431 **(Myrtle Beach)** Office**:** (843) 656-1942 **(Florence)**

Purpose of Disclosure please check the boxes below (required by HIPAA regulations):

To share information that is needed for the coordination of dental and/or denture services.

❑Copy of Dental Records (includes but is not limited to, office records, progress notes, discharge summaries, operative notes, results of X-ray or other radiological studies, copies of films and lab tests.)

❑ Copy of Billing or Other Information as specified: _____

I understand that my records are protected under the Federal Confidentiality Regulations as well as the provisions of HIPAA of 1996 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time, provided that action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon release of the information. The nature of this consent form has been explained to me and I understand its contents.

Client Signature : _____ **Date:** _____

Catholic Charities Staff Signature: _____ **Date:** _____

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Save a Smile Program Agreement

This statement defines and outlines the process for helping clients obtaining services from Sexton Dental (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 with Sexton.

_____ Client is responsible for attending all appointments with CCPD Case Manager

_____ Client is responsible for communicating with CCPD staff member with any issues.

_____ Client understands that CCPD is only providing payment for denture services as outlined per agreement with Sexton Dental.

Services include:

Economy Dentures (basic)

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

_____ Client understands that CCPD 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 Sexton Dental.

_____ 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 CCPD's Case Manager immediately for further discussion.

Client's Name Printed: _____

Client's Signature: _____ **Date:** _____

Receiving Staff Name Printed: _____

Receiving Staff Signature: _____

Date: _____

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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 Audra Naramore via email:

anaramore@charelstondiocese.org