Jewish Family Service
of Northeastern Pennsylvania

615 Jefferson Avenue
Suite 204
Scranton, PA 18510
(570) 344-1186
Fax (570) 344-7641
www.jfsnepa.org

**Jewish Family Service, in partnership with volunteer dentists from the Scranton District Dental Society and Fortis Institute, administers the DentalCare Center which provides professional dental services to those who meet specific eligibility requirements. All treatments are provided in private dental offices, with initial examination and diagnosis at Fortis Institute Dental Hygiene Clinic, Scranton.**

Preventive dental services provided at no cost are: exams, x-rays and cleanings. Restorative dentistry does require a minimal $10 office visit co-payment. Specialist treatment is provided by endodontists, periodontists, and oral surgeons. **Anesthesia, surgical extractions, root canals and laboratory fees involving dentures, partials, crowns and bridge work are the financial responsibility of the patient but can be provided at a reduced fee upon application approval.** We **do not** have dentists on staff; therefore, if immediate emergency care is needed and we are unable to assist you, we will refer you to an emergency room.

**To qualify you must meet the following criteria:**

- Be a resident of Lackawanna County for at least 6 months.
- Be a U.S. citizen or have proof of permanent legal status.
- NOT be enrolled in any creditable dental insurance plan or have the option to purchase a dental insurance plan through your employer.
- Meet the family size and income requirements as listed on the enclosed.
- Agree to the Patient Rights and Responsibilities, Terms and Conditions.

A person who is at least 18 years of age and head of an independent household must complete their own application. Members of a household under age 26, must be claimed as a dependent to be included in the financial eligibility assessment.

**HOW TO APPLY:**

To establish your eligibility for care in the Jewish Family Service DentalCare Center, it will be necessary for you to **complete the enclosed application and return it with copies of all required documentation.**

Please print clearly and answer all of the questions. Your application will be delayed in processing if the requested information is incomplete or is not enclosed.

- Copy of drivers license or state issued photo identification
- Copy of pay stubs for the past 2 months
- Copy of last W-2 form/Social Security Notice
- Copy of most recent tax return
- Proof of US Citizenship, i.e., Passport, Birth Certificate, Certificate of Naturalization
- $10.00 Application Fee to be made payable to **Jewish Family Service.** *Please do not send cash.* Check or money order is acceptable.

You may contact our office at (570) 344-1186 with any questions or concerns regarding our program application or services.

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of Northeastern Pennsylvania
*615 Jefferson Ave.*
*Scranton, PA 18510*
*570-344-1186*
*Fax 570-344-7641*

**FOR OFFICE USE ONLY**
Case No. _____
Eligibility Date _____
Expiration Date _____
Date Sent _____

# ***Jewish Family Service Dental Care Center Application***

## I: Identifying Information

Date: _____

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Length of time at above address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

How did you find out about our services?
_____

## II: Household Composition

List **ALL** people in your household (including yourself):

| Name | Date of Birth | Relationship | Social Security # | Access Card ? Y/N | Is this person a US citizen?* Y/N | Is this person a Lackawanna County resident longer than 6 months? Y/N | Is this person applying for dental care? Y/N |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

* If not a U.S. citizen, is this person a permanent legal alien? Yes ___ No ___ If yes, please attach a copy of permanent resident card.

**III: Income and Expenses**

**Income:**

Please list **all income** of everyone listed on this application:

| **Does anyone have income from:** Please circle **yes** or **no** | | | Whose income is this? | How often is the income received? (Weekly, Bi-weekly, Monthly) | Amount of monthly income | Hours worked per month |
|---|---|---|---|---|---|---|
| Employment | **YES** | **NO** | | | | |
| Employer's Name | | | | | | |
| Employment | **YES** | **NO** | | | | |
| Employer's Name | | | | | | |
| Self-Employment | **YES** | **NO** | | | | |
| Social Security Income | **YES** | **NO** | | | | |
| Pension/Retirement | **YES** | **NO** | | | | |
| Worker's Compensation | **YES** | **NO** | | | | |
| Unemployment Benefits | **YES** | **NO** | | | | |
| If yes, date benefits started: | | | | | | |
| Dividends/Interest | **YES** | **NO** | | | | |
| Child Support | **YES** | **NO** | | | | |
| Public Assistance | **YES** | **NO** | | | | |
| Seasonal Worker | **YES** | **NO** | | | | |
| Other | **YES** | **NO** | | | | |

If no income, are you currently seeking employment? Yes ____ No ____ If no, explain: _____

_____

_____

| **RACE/ETHNICITY:** | |
|---|---|
| White, Non-Hispanic | |
| Black, Non-Hispanic | |
| Hispanic | |
| Asian | |
| Native American | |
| Other | |
| Unknown race/ethnicity | |

**IV: Dental History**

Please complete this form for each family member requesting service.

Name of family member requesting service:_____

PLEASE DESCRIBE BRIEFLY WHAT THE PRIMARY REASON / CONCERN IS FOR SEEKING TREATMENT
If pain, please be specific as to site.

_____

DENTAL HISTORY

Date of last dental visit: _____ Reason for last dental visit:_____

Name of dentist seen at last dental visit: _____

Reason for past dental care:

- Mostly regular visits
- Mostly emergency visits
- Other_____

Types of past dental care:

- Caries/restoration during last year
- Caries/restoration more than 1 year ago
- Extraction(s). Total number _____
- Root canal therapy
- Crowns/Bridges
- Implants
- Dentures
- Periodontal therapy

**V: Your Rights and Responsibilities**

A copy of Jewish Family Service Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities-Terms and Conditions follows. Please sign and date the white copy of the Patient Rights and Responsibilities-Terms and Conditions and return with your application. Please retain the yellow copy of the Patient Rights and Responsibilities-Terms and Conditions and the Notice of Privacy Practices with your records.

**VI: Renewal**

Eligibility period for the JFS DentalCare Center remains active for a period of one year after acceptance into the program. Thirty days prior to your expiration date, you will be notified of completion of treatment or asked to submit a new application if continuation of care is requested and you continue to meet the eligibility requirements. To request a new application, please call the DentalCare Center at 570-344-1186.

## Jewish Family Service DentalCare Center

Jewish Family Service, in partnership with volunteer dentists from the Scranton District Dental Society and the Fortis Institute Dental Hygiene Clinic, administers the DentalCare Center which provides professional dental services to those who meet specific eligibility requirements. Diagnosis and treatment is initially provided by dental students under the supervision of Fortis Institute Faculty at the Fortis Institute Hygiene Clinic.

### Patient Rights and Responsibilities
### Terms and Conditions

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility into the Jewish Family Service DentalCare Center.

I understand that I can request an impartial review of an eligibility determination if I do not agree with an eligibility decision made on this application.

**If accepted into the program:**

When appointments are assigned, I will keep the appointment unless unforeseen difficulties arise such as illness, bad weather or an emergency. If an unforeseen difficulty arises and I am unable to keep my appointment, I will contact the Fortis Institute Dental Hygiene Clinic or the dentist's office as soon as possible to cancel my appointment. If I do not cancel my appointment prior to the appointment time, I understand I **will** be excluded from the dental program. I will also contact Jewish Family Service to inform them of any change in appointments. The dentists from the Scranton Lackawanna County District Dental Society volunteer their services to help those in need with no compensation for themselves. Therefore, it is imperative that you keep your appointment.

Appointments will be scheduled by me with the proper approval and paperwork from the Jewish Family Service staff according to the availability of the dentists. I understand that I may be placed on a waiting list until an appointment with a dentist is obtainable.

I understand that I must report all changes in my household or financial situation to Jewish Family Service within one week.

I have read and fully understand this application. The information that I have given is true and correct. I understand there may be penalties for knowingly giving false information. I understand that failure to comply with the above listed responsibilities may deem me ineligible for program services.

I hereby authorize the referral to the volunteer dentists from the Scranton District Dental Society and the Fortis Institute Dental Hygiene Clinic to diagnose, make recommendations and perform the necessary course of dental treatment. I understand I will be advised of the nature of the dental services to be provided. I will also be advised of, and fully understand the risks and benefits that normally result from and are involved in the performance of dental services. I understand that I may refuse to consent to any and all treatments or procedures.

By signing below, I acknowledge that I have read and understand the Patients Rights and Responsibilities-Terms and Conditions. I also acknowledge that I have received the Notice of Privacy Practices for my review.

_____ _____

Signature of applicant or person applying for applicant(s) Date

**ELIGIBILITY**

To be eligible for care through the Jewish Family Service DentalCare Center, your gross monthly/annual income must be at least 100% of the Federal Poverty Level, but less than 200% of the Federal Poverty Level.

If your income is below the amount listed, you may be eligible for Medical Assistance. For more information please contact the Lackawanna County Department of Public Assistance at 570-963-4525.

| FAMILY MONTHLY GROSS INCOME LEVELS* | | |
|---|---|---|
| FAMILY SIZE | 100% of Poverty | 200% of Poverty |
| 1 | $1,012 | $2,023 |
| 2 | $1,372 | $2,743 |
| 3 | $1,732 | $3,463 |
| 4 | $2,092 | $4,183 |
| 5 | $2,452 | $4,903 |
| 6 | $2,812 | $5,623 |
| 7 | $3,172 | $6,343 |
| 8 | $3,532 | $7,063 |

Add $360 for each person over 8 people in your household

*These income levels are based on the 2018 Federal Poverty Level Guidelines

| **FAMILY YEARLY GROSS INCOME LEVELS*** | | |
|---|---|---|
| FAMILY SIZE | 100% of Poverty | 200% of Poverty |
| 1 | $12,140 | $24,280 |
| 2 | $16,460 | $32,920 |
| 3 | $20,780 | $41,560 |
| 4 | $25,100 | $50,200 |
| 5 | $29,420 | $58,840 |
| 6 | $33,740 | $67,480 |
| 7 | $38,060 | $76,120 |
| 8 | $42,380 | $84,760 |

Add $4,320 for each person over 8 people in your household

*These income levels are based on the 2018 Federal Poverty Level Guidelines

# Jewish Family Service of Northeastern Pennsylvania

## Notice of Privacy Practices
## Effective Date: April 14, 2003

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment and health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by the clinical staff, our agency staff and others outside of our agency that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and other required operational expenses to support your services.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a hospital or agency that provides care to you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan (including Medicare and Medicaid) may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of Jewish Family Service of Northeastern Pennsylvania. These activities include, but are not limited to, quality assessment activities, employee review activities and licensing. We will share your protected health information with third party "business associates" that perform various activities (e.g., transcription services) for the organization. Whenever an arrangement between our organization and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

**Marketing -**Jewish Family Service of Northeastern Pennsylvania occasionally asks clients and/or families to share their stories and the care they received for our marketing brochures.

**Fund Raising -**Jewish Family Service of Northeastern Pennsylvania may contact you, family member(s) or friends asking for support of our work by donating goods or services, or making a monetary contribution.

Uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your social worker or Jewish Family

Service of Northeastern Pennsylvania has taken an action relying on the use or disclosure indicated in the authorization. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

## OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

a. The disclosure is permitted by an appropriate court order.
b. The disclosure is made to medical personnel in a medical emergency.
c.The disclosure is made to qualified personnel and grantees for research, or for program audit or program evaluation including peer review and utilization reviews of client records.
d. The information disclosed relates to a report of child or elder abuse and/or neglect. Jewish Family Service of Northeastern Pennsylvania employees are required by law to report to the proper authorities any abuse or neglect incident that may be disclosed to staff.

**Right to Request a Restriction of Protected Health Information**: You have the right to ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer at the address listed at the completion of this Notice. Your request must state the specific information to be restricted; if you want to limit our use, disclosure or both; and to whom you want the restriction to apply.

**Right to Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

**Right to Amend Protected Health Information**: You have the right to request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please make any request for amendment in writing to our Privacy Officer.

**Right to Receive an Accounting of Certain Disclosures**: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made with your authorization to you, to family members, or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You must submit any request for an accounting of disclosures in writing to our Privacy Officer. We may charge you a fee for the cost of providing the accounting.

## COMPLAINTS

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201, if you believe your privacy rights have been violated by us. You may file a complaint with us by sending a letter addressed to our Privacy Officer, Jewish Family Service of Northeastern Pennsylvania, 615 Jefferson Avenue, Suite 204, Scranton, PA 18510. We will not retaliate against you for filing a complaint.

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_____ _____

Signature of applicant or person applying for applicant (s) Date

Patient Copy- Please maintain for your records.