Logo, company name

Description automatically generated

**SMILE ON 65+ Referral Form**

**Referral Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI: \_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Information:**

**Phone Number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_**

**Smile On 65+ Demographic Information:**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender: \_\_\_\_\_Female \_\_\_\_\_Male \_\_\_\_\_\_ Transgender \_\_\_\_\_Unknown/Other**

**Race/Ethnicity: \_\_\_\_\_\_Caucasian \_\_\_\_\_\_African American \_\_\_\_\_Hispanic**

**\_\_\_\_\_Asian \_\_\_\_\_\_American Indian/Alaska Native \_\_\_\_\_Pacific Islander**

**\_\_\_\_\_\_\_Multi-Racial \_\_\_\_\_\_\_Unknown \_\_\_\_\_Prefer Not to Answer**

**Does the client receive any of the following?** (Select all that apply)

**\_\_\_\_\_\_\_\_SNAP/Food Stamps \_\_\_\_\_\_\_\_TennCare/Medicaid \_\_\_\_\_\_\_\_\_Section 8/Low**

**Income Housing \_\_\_\_\_\_\_\_SSI/SSDI**

**Is the Client a Veteran? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**When is the last time the client visited a dentist?**

**\_\_\_\_Less than 12 Months \_\_\_\_\_1-2 years \_\_\_\_3-5 years \_\_\_\_ More than 5 years**

**What has kept the client from seeing a dentist regularly?**

 Transportation  Dental Cost  No Insurance

 Personal Isolation  Fear  Physical mobility and health

**Current dental issues (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does the client have DENTAL insurance? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ Unsure**

**If Yes – Type/Plan (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does client need help using**

**benefits? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_Unsure**

**Household Income:**

**$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of people in household\_\_\_\_\_\_\_\_\_\_**

**Does the client pre-qualify for SMILE ON 65+ (age, residence, income, and insurance**

**criteria met)? \_\_\_\_\_Yes \_\_\_\_\_No**

**For eligibility verification, please attach the following:**

**-Proof of Household Income (proof of any income received for all adults in the household)**

**-Copy of all medical and/or dental insurance cards, including Medicare**

**-Proof of Age and Tennessee residence (copy of drivers license or state ID card fulfils both; otherwise include one legal document verifying DOB (passport, birth certificate, social security documents) and one verifying proof of address (utility bill, bank statement, etc.)**

**Fax completed referral form and eligibility documents to 615-988-9244**

**or email to** [**mattie@smileon65plus.com**](mailto:mattie@smileon65plus.com)