DECOD Eligibility Form

Welcome to the Dental Education in the Care of Persons with Disabilities (DECOD) Program. The DECOD Clinic serves people with developmental and acquired disabilities, as well as residents of specific care facilities. Adults with DDA Medicaid benefits are usually eligible for DECOD services and make up 90% of the DECOD Clinic patient population. Individuals with acquired disabilities may be eligible for services in the DECOD Clinic or elsewhere in the UWSOD system. If you would like to be screened for eligibility, please fill out the following form.

Patient Registration

First Name		Middle Name	Last Name	
Date of Birth	Gender	Pronouns (optional)	Social Security Number (optional)	
Address			Method of Payment (please attach insurance card)	
			☐ Medicaid (Apple Health) ☐ Self-pay ☐ Private Dental Insurance ☐ Other	
City		State	ZIP	Provider One Number (Medicaid/Apple Health)
Home Phone		Other Phone	Email (optional)	

Eligibility Screening

Do you have any of these conditions? You could be eligible for DECOD services if you have one or more of these conditions.		Do you have DDA Medicaid benefits? Adults with DDA Medicaid benefits are typically eligible for DECOD services.
☐ Autism	☐ Multiple sclerosis	☐ Yes
☐ Cerebral palsy	☐ Parkinson's disease	☐ No
☐ Down syndrome	☐ Muscular dystrophy	☐ Unsure
☐ Intellectual disability	☐ Huntington's disease	**Are you a resident of Providence Mount St. Vincent?** Residents are typically eligible for DECOD services on site at Providence Mount St. Vencent.
☐ Other developmental disability	☐ Amyotrophic lateral sclerosis (ALS)	
☐ Traumatic brain injury	☐ Spinal Muscular Atrophy	☐ Yes
☐ Stroke	☐ Other:	☐ No
☐ Spinal cord injury		
*Referred by (if applicable): ☐ UW Center for Pediatric Dentistry ☐ UW General Practice Residency ☐ UW Transition Care Program		***For Official Use Only:** ☐ Eligible for DECOD Services ☐ Eligible for DECOD Supplement D0999D ☐ Urgent Case

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Communication and Decision Making

Appointment scheduling:	
Who is the best contact for scheduling your appointments?	Contact name:
	Contact phone number:
What is their relationship to you?	Contact email:

I need an interpreter.

☐ Yes   →   Type of interpreter needed:

☐ No

Other communication needs (if applicable):

I will have a caregiver, family member, or other support person accompany me to the appointment.

☐ Yes   →   Who will accompany you?

☐ No

I make my own health care decisions.

☐ Yes

☐ No

I have a legal guardian who helps me make medical decisions. A legal guardian is a court-appointed decision-maker.

☐ Yes   →   Guardian name:

☐ No   Guardian relationship:

                  Guardian phone:

                  Guardian address:

I have some other form of support for decision-making (e.g. power of attorney, friend, family member, etc.)

☐ Yes   →   Support person name:

☐ No   Support person relationship:

                  Support person role in decision-making:

                  Support person phone number:

Eligibility form completed by:

Relationship to patient:

Signature: **Today's date:**