Mississippi Health Care Foundation
Medical & Personal Needs Grant Application - Dentures

This form is to be used with the grant application information sheet when submitting a funding request for dentures for an individual resident at a Mississippi-licensed skilled nursing care facility. **Please answer each question with as much detail as possible.** If additional space is needed, please use additional pages, noting to which question or section the extended answer belongs.

Resident Name: _____

Resident Age: _____ Resident Gender: _____

Admit Date to Facility: _____ Expected Date of Discharge: _____

Resident considered: Short-term stay _____ Long-term stay _____

Resident Primary Pay Source at Facility: _____

Facility Name: _____

Facility Mailing Address: _____

Facility City/State/Zip: _____

Facility Phone Number: _____ Facility Fax Number: _____

Contact Email Address: _____

Type of Dentures Being Requested: ☐ Full Set ☐Upper Dentures ☐Lower Dentures
☐Full Partial ☐Upper Partial ☐Lower Partial

Other Repairs (related to dentures, partials, etc.): _____

This application must have the signature of the Facility Administrator and at least one other facility staff member (must be Social Work Director, Activity Director, or Director of Nursing or other appropriate staff).

Administrator's Signature: _____

Secondary Signature & Title: _____

Mail to:

Mississippi Health Care Foundation
303 Brame Road
Ridgeland, MS 39157

Or fax to: 601-898-8341

For Foundation Office Use Only

_____ Date Received _____ Date Reviewed A B C Circle Review Method

_____ Approved _____ Not Approved Approved $_____

_____ Notification Sent _____ Check Sent Check #_____

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Please be sure each question is answered with as much detail as possible before submitting application.
Use additional pages if more space is needed and identify the question being addressed.

1. When was the last time the resident had his/her own teeth or wore dentures? (Specify own teeth or dentures) _____

2. If the resident has been without teeth/dentures 1 year or more, explain why dentures are needed at this time.

_____

_____

3. If the request is to replace dentures, explain why the dentures need to be replaced.

_____

_____

4. If dentures have been lost or broken, give a detailed description of how the dentures were lost/broken and if lost, explain what has been done to try to find the dentures. (Please review page 4 regarding Foundation policy for lost/broken items.)

_____

_____

5. If the request is to replace lost/broken dentures, what action is being put in place to try to prevent loss/breakage of dentures?

_____

_____

6. How will the resident benefit from having dentures?

_____

_____

7. Describe the resident's current physical condition, health status, and mental status.
Physical condition: _____

_____

Health status: _____

_____

Mental status: _____

_____

8. What type of diet is the resident receiving?

_____

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9. If resident on regular diet, what has changed to cause need for dentures?

_____

_____

10. What resources does the resident have that may possibly be used to assist with the purchase of dentures? (Attach copy of residents account to show account balance.)_____

11. What resources does the family have to assist with the purchase of dentures?

_____

12. What resources are available at your facility to help meet need and/or what your facility may be contributing to meet the resident's need?

_____

13. Describe other resources, if any, explored. If funding was sought from other resources, explain why such funding was not granted.

_____

14. Why is this request being made to MHCF?

_____

Attach confirmation from a dentist that the resident is a candidate for dentures.

Attach any comments from nursing, therapy or others about why this request is being made for the resident and why they think it would be of benefit to the resident

Attach written estimate of the cost of dentures from the potential vendor. * The Foundation does not pay for dental visits or consults. The facility is responsible for arranging for payment for this type of service.

*MHCF staff can be contacted for possible resources of reasonable priced dentures.
If a complete set of dentures exceeds $800.00, attach quotes from at least 2 providers.
If an upper or a lower set of dentures exceeds $400.00, attach quotes from at least 2 providers.

Completed applications should be mailed to:
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Ridgeland, MS 39157

Or fax to: 601-898-8341

Please be sure each question was answered with as much detail as possible. Incomplete applications will be returned to the facility. MCHF reserves the right to request additional documentation and/or information.

Applications received by the 10th of the month will be reviewed for notification to the facility by the 10th of the following month. Applications received after the 10th of the month will be held for the next review period. It is estimated that it will take 3-4 weeks for review and notification to the facility.

If you have questions or need additional information, please contact MHCF at 601-898-8320.

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Policy re: Lost/Broken Items

The Mississippi Health Care Foundation receives frequent requests to replace items that are lost or broken in the nursing home. It is the general policy of the Foundation that the replacement of items lost in the facility is the responsibility of the facility. The general policy for broken items is that this is also a facility responsibility unless justification can be provided that the item is broken due to age, normal usage by the resident, etc.

If the item was purchased by the Foundation and lost or broken within 12 months of the date of purchase, the Foundation will not consider replacing the item. If it has been more than 12 months, the policy in the above paragraph will be applied.