Arizona Health Care Foundation Live-A-Dream - Dental

About AHCF & The Award

The Arizona Health Care Foundation (AHCF) wants to make dreams a reality for AHCA member residents in long term care and assisted living centers. The *Live a Dream* Award program attempts was established to assist in granting those dreams if possible. Recipients are selected by the Arizona Health Care Foundation on the basis of our ability to fulfill the dream. Applications will be reviewed by the AHCF Board of Directors.

Live-A-Dream Criteria

The Arizona Health Care Foundation is deeply committed to assist residents with dental needs. However, due to the high cost and complexity of services required, AHCF cannot always meet all funding requests in full. The maximum award is generally around $1,000 per request after all other financial resources have been explored. Award recipients must be a resident in an Arizona Health Care Association member facility.

Applications should be sent to: Arizona Health Care Foundation, Attention: Live-A-Dream, 3003 N. Central Avenue, Suite 860, Phoenix, Arizona 85012.

For additional information or clarification call AHCF at (602) 265-5331 or email kdobson@azhca.org.

Type or Print Clearly:

Name of Nominee: _____

Facility: _____

Address: _____

City / State / Zip: _____

Phone: _____ Email: _____

Your Name & Title: _____

Please complete the following questions:

1. Describe the dental needs of the nominee and why they are deserving:

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. A quote is required for AHCF consideration. Has a quote been received from the dentist for services needed? ☐ **Yes** ☐ **No**

If **Yes**, please provide a copy of the quote with this application. If **No**, please send as soon as possible.

3. What is the projected cost of the dental work? _____

4. In many cases the facility is able to contribute to the cost. Please indicate the amount the facility can contribute. _____

5. Who is the key contact at the facility?

Name: _____

Phone: _____

Email: _____

6. Is the Resident covered by AHCCS or ALTCS? ☐ **Yes** ☐ **No**

If **Yes**, what will be covered? _____

_____

If **No**, please state the reason for non-coverage? _____

_____

7. Which AHCCS / ALTCS managed care company coordinates their care?

_____

_____

8. Can this Resident's "Share of Cost" be temporarily reduced to pay for this service? ☐ **Yes** ☐ **No**

If **Yes**, what is their Share of Cost? _____

_____

If **No**, why? _____

_____

9. Has a request for assistance been discussed with the AHCCS / ALTCS Case Manager?

☐ **Yes** ☐ **No**

If **Yes**, please provide a copy of any written response.

10. Please identify the AHCCCS / ALTCS Case Manager:

Name: _____

Phone: _____

Email: _____

11. Has the Resident been seen by a dentist? ☐ **Yes** ☐ **No**

Name of Dentist: _____

Phone: _____

Email: _____

12. Will facility staff be available to assist in fulfilling this wish?

☐ **Yes** ☐ **No**

13. Is there any additional information regarding this Resident that we should know about in order to consider this request?

_____

_____

_____

_____

14. If awarded, to whom should the check be made payable?

_____

_____

Please note that a medical release and a liability waiver will be requested prior to granting any wish.

Name of Administrator (print): _____

Signature: _____ Date: _____

Additional comments from the Administrator / Manager:

_____

_____

_____

Standard Media Release Form

I authorize _____ to create photograph, video and audio recordings of me as well as written or recorded oral descriptions. These materials will be used for marketing purposes. I understand that _____ may revise, annotate, edit and otherwise alter the recorded material to emphasize certain aspects of my projects and me. I understand that _____owns all copyright to these materials. I hereby release _____ and its employees from any and all claims of any nature whatsoever which now or may hereafter have in connection with these recorded materials, including but not limited to claims based on defamation, copyright infringement, trademark infringement, infringement of may right of privacy or of my right to publicity.
I authorize _____ to publish photographs, video or audio of me as well as written or recorded oral descriptions on the World Wide Web.

Name:_____

Signature:_____

Date:_____