



www.FAIRFoundation.org

To Whom It May Concern:

The FAIR Foundation and the American College of Prosthodontists have developed a national dental plan for transplant patients.

We will attempt to provide access to pro-bono dental care to assist a qualifying transplant patient in his/her attempt to be listed, or re-listed, for transplant.

The patient must meet the following requirements to qualify for this dental assistance plan:

1. The patient must provide FAIR with a brief, signed statement which states that he/she cannot afford the needed dental treatment,
2. The patient must supply FAIR with a copy of their most recent tax return,
3. The patient must have passed **all** required pre-transplant tests, as performed by their transplant team, except for failure of the dental test due to existing dental disease.
4. The "Dental form for completion by transplant patient and transplant physician" must be completed and returned to the FAIR Foundation.
5. The patient must sign and return the HIPAA Authorization Form.

Should a patient meet the requirements as stated above, they may submit the required information to the FAIR Foundation (see contact information below). We will then begin the process of locating a dentist in the patient's geographic area to remove the dental disease; however we cannot guarantee that we will be able to accomplish this goal in every instance in which it is requested.

You may phone me at the number below should you have any questions.

Sincerely yours,

A handwritten signature in black ink that reads "Dr. Richard Darling, DDS".

Dr. Richard Darling, DDS: Past National Public Citizen of the Year (NASW)

President and CEO: The FAIR Foundation

Founder: The FAIR Foundation Liver Disease & Transplant Support Group

Author: Coma Life, an autobiographical memoir of survival over hepatitis C induced liver cancer, coma, 3 liver transplants

Dear Transplant Patient,

It has been brought to the attention of the FAIR Foundation that you need dental care to qualify for transplant. The FAIR Foundation has a dental program in conjunction with the American College of Prosthodontists. This dental plan provides pro-bono dental care in some instances for patients who cannot afford the needed dental treatment.

If you would like to be considered for this program, you and your transplant team **must send** the following information to us by postal mail at the address below or fax to 760-772-9741:

1. **completed dental application and HIPAA forms,**
2. **a copy of your most recent tax return,**
3. **a brief signed statement from you, the patient, which states that you cannot afford the needed dental treatment.**

We will make every effort to locate a dentist to help you at no charge to you; however, in some instances there may be some fees that you will be required to pay. If you still opt for the treatment, those fees will be your responsibility.

God Bless,



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President and CEO: The FAIR Foundation
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The FAIR
 Fair Allocations In Research
FOUNDATION

www.FAIRFoundation.org

Dear Transplant Physician,

The FAIR Foundation is a national organization which, in conjunction with the American College of Prosthodontists, has assisted in providing access to pro-bono dental care for patients in need of such care to be listed, or re-listed, for transplant when the patient cannot afford such dental treatment. The patient must have completed all other UNOS required pre-transplant testing requirements for listing (cardio, etc.) prior to our being contacted for help. If you are treating a patient who meets these requirements, please complete the attached form so the patient can return it to us. We will make every effort to provide the necessary dental care, but we cannot guaranty this in all instances.

Thank you for your cooperation in this effort to help your patient and please know that you can phone me any time for more information on this transplant assistance policy.

Sincerely,

Richard Darling, DDS

Dr. Richard Darling, DDS: Past National Public Citizen of the Year (NASW)
 President and CEO: The FAIR Foundation, a national organization with thousands of members in favor of fair research funding & new organ-donor policies to reverse our organ-donor crisis
 Founder: The FAIR Foundation Liver Disease & Transplant Support Group
 Author: Coma Life, an autobiographical memoir of life "within" coma and survival over hepatitis C induced liver cancer, coma, 3 liver transplants, heart attack, diabetes & MS

Disease	2011 NIH Research \$	Deaths Per Disease	\$ Per Patient Death	\$ Per Patient
COPD	101 Million	126,128	811	7
Hepatitis C	102 Million	12,000	8,500	23
Cardiovascular	2.1 Billion	864,280	2,429	26
Hepatitis B	54 Million	5,000	10,800	43
Diabetes	1 Billion	72,449	13,803	42
Alzheimer's	480 Million	71,696	6,626	92
Parkinson's	171 Million	19,566	8,739	171
Prostate Cancer	329 Million	28,372	11,595	219
HIV/AIDS	3.2 Billion	14,110	225,656	3,032
All Cancers	6 Billion	559,888	10,716	4,152
Breast Cancer	765 Million	41,210	18,563	4,238
West Nile Virus	41 Million	28	1,464,285	64,364

HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)****

1. I authorize the FAIR Foundation officers to use and disclose the protected health information described below to the FAIR Foundation Board of Directors and the American College of Prosthodontists staff and dentists working to provide dental care for me in their effort to assist me in being listed for transplant.
2. This authorization for release of information covers the period of healthcare from all past, present, and future periods.
3. I authorize the release of my complete health record without exception.
4. This medical information may be used by the FAIR Foundation officers and its dental team for medical treatment, consultation or other purposes as I may direct.
5. This authorization shall be in force and effect until I retract it in writing to the FAIR Foundation by email at fair@dc.rr.com or by postal mail to FAIR Foundation, 78-629 Bougainvillea Drive, Palm Desert, CA 92211.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
7. I understand that my dental treatment, enrollment, and/or eligibility for dental care are conditioned on whether I have agreed to, and sign, this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative if patient is a child:

Printed name of patient or personal representative and his or her relationship to patient

Date _____

