Dental Services Assistance Application

Date:_________________________

Patients Name: ____________________________ Date of Birth:_______________________

Address:____

____

Daytime Phone: _______________________________ Other Phone:________________________

Number of members in your household: Adults: _______ Children: _______

Members of the household that are employed: (please provide copies of last 4 pay stubs or state award letter for income or copy of IRS form 1040.)

Name:___________________ Employer:_____________________ Gross monthly income:___________

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Do you or your family receive Food Stamps: Yes or No Amount:_________

Do you or any members living in the home receive housing assistance: Yes or No Amount:_______

Do you or any members living in the home receive fuel assistance: Yes or No Amount:_________

Child support/Alimony: Yes or No Amount:_____________

Please list any other income for you or any other household member:

1.____

2.____

3.____

Please complete this form and supply copies of the following

- Income for the household
- Photo ID for person applying.
- If you are self-employed please provide bank statement and last year's tax returns
- Must be on Medicaid or have a denial letter to be eligible for assistance.

Office Use Only:
Total Income______________ Family Size_____________ Medicaid___________
Slide Level 100% 75% 50% 25% Self Pay
Signature_______________________________ Date________________