**Douglas County Health Department**

**Dental Access Program**

**Application**

The Douglas County Health Department Dental Access Program (DAP) is a program through which dental services are provided at a reduced fee to people who have no dental insurance. This program is based on the total income and the household size. Patients are interviewed for dental program eligibility via this form. If eligible, you can receive dental services for reduced fees at the Douglas County Health Department Dental Clinic. These discounted fees are based on Medicaid reimbursement rates.

**PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION.** We reserve the right to request proof of income.

Last Name: First Name: M.I.\_\_\_\_\_\_\_\_\_\_

Residence Address:

City: State: Zip:

Date of Birth:

Phone: ( ) Alternate Phone :( )

**HOUSEHOLD INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name (including yourself) | Relationship to you | Date of Birth | Sex |
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**Please list everyone in your household (including yourself) for whom you are seeking a reduced rate.**

**Income Information**

List any employer wages, earnings or money from a job or from self-employment that you, your spouse or others who are listed above.

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| --- | --- | --- | --- | --- |
| Name of Employed Person | Name of Employer | Address of Employer | Work Telephone Number | Gross Amount (amount before taxes-weekly) |
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**Other Resources**

List any alimony, child support, pension, Social Security, rental income, retirement, unemployment, veterans, or workers compensation benefits that you, your spouse or others in your household may receive.

|  |  |  |  |
| --- | --- | --- | --- |
| Person Receiving Benefit | Type of Benefit | Amount Received | How Often? |
|  |  |  |  |
|  |  |  |  |
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**Confidentiality & Release of Information**

I agree to the release of personal and financial information from this application form to the Douglas County Health Department determining eligibility for the DAP Program (Dental Health Program), so that agency representatives can evaluate it and verify eligibility. I understand that I may be asked to provide additional information. Officials of the DAP Program may verify all information on this form. I understand that I must tell the agency that determines my eligibility about any changes in information on this form. By signing this application, I certify under penalty of perjury that everything on this form is the truth. All information and documentation gathered for determining eligibility is confidential. Disclosure of information concerning my eligibility to anyone not authorized to receive this information is violation of State and Federal Laws. The application must be signed by a household member 18 years of age or older.

Signature of Applicant Date