BRING COMPLETED APPLICATION BACK TO CARES OFFICE FOR APPROVAL

# ADULT DENTAL ASSISTANCE PROGRAM APPLICATION

**Alleghany C.A.R.E.S. Inc.**

**DATE:_____**

**CLIENT NAME_____Phone_____**

**Mailing Address_____**

**_____County_____**

**City_____, NC Zip_____**

**Emergency Contact:_____ Phone:_____**

## Household Information

| | Name | DOB | Sex | Social Security | Employed Yes/No | Disabled Yes/No | Relationship to Client |
|---|---|---|---|---|---|---|---|
| **Applicant** | | | | | | | |
| **Spouse** | | | | | | | |
| **Child** | | | | | | | |
| **Child** | | | | | | | |
| **Child** | | | | | | | |
| **Other** | | | | | | | |

## DENTAL INSURANCE

**Do you have private or employer dental insurance?**

Do you have Medicaid? (Circle One) Yes/No

Are you a Veteran? Yes/No Are you receiving dental benefits? Yes/No

## Current Gross Monthly Household Income

| | | Applicant | Spouse | Other member |
|---|---|---|---|---|
| 1 | Work (Salary + Cash payments) | | | |
| 2 | Rental Income | | | |
| 3 | Work First | | | |
| 4 | Alimony | | | |
| 5 | Child Support | | | |
| 6 | Unemployment Compensation | | | |
| 7 | Social Security or SSI | | | |
| 9 | VA Benefits | | | |
| 10 | Pension Payments | | | |
| 11 | Annuity Payments/Investment Income | | | |

**Total Household Income$_____**

**100% Poverty level for size family$_____**

**Please list all assets including *land* other than your home, *checking accounts, savings accounts, Money Market accounts, stocks, mutual funds, CDs or retirement accounts.***

| Asset | Value |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Do you anticipate significant changes in Household Income or Assets?** Yes/No

If yes, Please explain _____

## Patient Information

What is the problem with your teeth that you are seeking from this program?

_____
_____
_____
_____
_____
_____
_____

**Drug Allergies**

_____Penicillin
_____Sulfa
_____Codeine
_____Erythromycin
_____Aspirin
_____Other_____
_____Other_____
_____Other_____

**Current Medications:**

_____ _____
_____ _____
_____ _____
_____ _____

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## Disclosure Permission

I hereby permit the staff of Alleghany C.A.R.E.S. Inc. to contact any person or agency to discuss issues surrounding my application for assistance. I also verify that the information given above is truthful and that I have not made any attempts to misrepresent my need for assistance.

I agree to report any change in income or insurance immediately and understand that failing to do so may result in being ineligible for future assistance through the program.

In consideration of the free dental care services received, I for myself and anyone entitled to claim through me, do hereby waive and release Alleghany CARES and any other dentist partnering with Alleghany CARES from all claims of liability arising out of my acceptance of such free dental care. (3 appointment at a $250 value unless an exception is given by Alleghany CARES director).

I have read, or had read to me, and understand and agree to all of the above.

Date: _____

Client Signature: _____ Date_____

Staff Signature:_____Date_____