



## Application for participation in the Elder Dental Program

This form will be used to determine if you are eligible for the Elder Dental Program. The program does not provide free care—it connects you with a dentist who has agreed to charge you special, reduced fees. These fees have been set by the program and are tied to your income level.

### Applicant information

Name:

Phone Number:

Street Address:

Town:

State:

Zip Code:

Date of Birth:

Gender:

Marital status:  Single/Divorced/Widowed  Married

How did you hear about this program?

Are you on MassHealth?  Yes  No

(If you are, you can still participate in the Elder Dental Program, but you should know that MassHealth is now paying for dental care for adults, starting in July 2006. To learn more, call MassHealth at 1-800-841-2900.)

Do you currently have a dentist?  Yes  No

Are you able to walk up stairs?  Yes  No

Do you have transportation to get to an appointment?  Yes  No

## Oral health questions

1. Do you wear dentures?  Yes  No
2. When was your last cleaning?
3. Is anything hurting you now?  Yes  No  
If yes, explain:
4. Do you have any visible swelling in your mouth?  Yes  No  
If yes, explain:
5. Do you have any bleeding in your mouth or gums?  Yes  No  
If yes, explain:
6. Are any of your teeth loose?  Yes  No  
If yes, explain:
7. Do you have anything you'd specifically like a dentist to look at?  Yes  No  
If yes, explain:
8. Do you need pre-medication of antibiotics before dental work?  Yes  No

# Financial information

This section helps us figure out if you are eligible for the program. **You must include documentation regarding your Social Security income and a copy of your most recently filed federal tax return.**

## Income

Please complete this section about other income (**before** taxes and deductions).

**\*\*\* If you are married, include your spouse's income.**

Type of income	Amount received per year	Comments
Social Security	\$	
Railroad Retirement	\$	
Veterans' Benefits	\$	
Retirement Funds	\$	
Wages	\$	
Pensions	\$	
Alimony	\$	
Other Please specify:	\$	

## Resources

Resources usually include anything that can be turned into cash within 20 days.

Type of resource	Value	Comments
Checking account	\$	
Savings account	\$	
Certificates of Deposit (CDs)	\$	
IRA	\$	
Stocks	\$	
Other	\$	

## Guidelines for Income Documentation:

- Please do not send original documents, only photocopies.
- Please provide a copy of your most recently filed federal tax return.
- Please provide **one** of the following documents to verify your Social Security Income
  - Annual Benefit Statement (SSA -1099 form)
  - Annual award letter from the Social Security Administration
  - A benefit verification letter from the Social Security Administration detailing income received within the past 12 months.
- If you do not have one of these documents, you may request a benefit verification letter by calling 1-800-772-1213, 7a.m. -7p.m., Monday –Friday, or by contacting your local Social Security Administration Office.
- Additional documents may be requested to verify resources.

## Assignment of Rights

*Please read this section carefully and sign at the bottom.*

I realize that the dental care offered by dentists in the Elder Dental Program includes diagnosis, fillings, cleanings, and other basic procedures. I will be referred to dental schools for dentures and other similar restorative work.

### **I understand that I have certain rights:**

- I understand that I have the right to be treated with respect.
- I understand that my financial information will be kept confidential.
- I understand that my dental and medical information will be kept confidential.
- I understand that I will be told how much I should expect to pay before my dental appointments.

### **I understand that I have certain responsibilities:**

- I agree to keep appointments with my dentist. **If I am unable to keep an appointment, I will reschedule with 48 hours' notice.**
- I agree to follow my dentist's instructions faithfully – and to ask questions so that I make sure I understand those instructions.
- I agree to pay my dentist at the time of the appointment.
- I agree to call the program manager immediately if I have a concern with or question about anything that happens at my dentist's office.

All information in this application is true to the best of my knowledge. I agree to provide additional documentation upon request.

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Signature of Applicant

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Date

**Mail completed forms to: The Elder Dental Program  
c/o Norfolk Adult Day Health Center  
595 Pleasant Street, Norwood, MA 02062**

*The Elder Dental Program is a project of HealthCare Options  
and the Neponset Valley Community Health Coalition.*