



**Montgomery County Adult Dental Program
(19 TO 59 YEARS OF AGE) WITH NO DENTAL INSURANCE**

General dental care, including emergency dental services, is provided to adults 19 to 59 years of age. Patients in need of specialty dental care are given information for appropriate resources for follow up care.

ALL APPROVED PATIENTS MUST PAID A FLAT FEE
\$20.00 PER ROUTINE VISIT
\$30.00 PER EMERGENCY

* Please provide copies of the following documents displaying applicant's name and current home address *

Name of Client: _____

Address: _____

Date of Birth: _____ Age: _____ (If you are 60 years old and over, you can apply for the senior dental program)

Gender: Male Female Transgender Decline to answer

Race: White Black Asian Other Would you need language assistance?: Yes No

Ethnicity: Hispanic Yes No Country Of Origin: _____

Phone number: () _____ - _____ Cell: () _____ - _____

* This program is only intended for patients with no dental insurance and can not be used as a supplemental dental coverage. *

Are you a Montgomery Cares Patient?: Yes No CHL# _____
(Mercy Clinic, Proyecto Salud, Holy Cross, Spanish Catholic, Community Clinic, etc)

Are you or any of your family members participants of any of the programs listed below?:

- Care For Kids Member# (For Example: P-12345): _____
- Maternity Partnership Expiration Date: _____
- Senior Dental Program

Do you have medical insurance?: Yes No Name of insurance: _____ # _____
(If you currently have medicare or medical assistance, please provide a copy of your insurance card)

Are you head of household?: Yes No Name of head of household: _____
(Have family members who depend of your income)

Number of people in household: _____ How many are under 18 years old?: _____
(Only include people who depend of your income)

*Include wages and salary, unemployment benefits, workers compensation, food stamps, disability and retirement benefits, etc.

Source of Income: _____ Total \$ _____ Weekly Biweekly Monthly Annualy
Food Stamps (If applicable): \$ _____ Unemployment Benefits (If applicable): \$ _____
SSI or Disability Benefits: \$ _____ Other: \$ _____

I affirm that all information I provided is true and give permission for pertinent information and documentation to be released to the Montgomery County Adult Dental Program.

Printed Name: _____ Signature: _____

Submit this form with all documents required to:
The Montgomery County Adult Dental Program
1401 Rockville Pike, 3rd Floor
Rockville, Maryland 20852
Office: 240-777-1659 Fax: 240 777-1818

TO BE COMPLETED BY SCREENER:

Is the client Eligible for Dental Services?: Yes No

* Screeners please confirm and verify client residency, age and income documents for submission*

ELIGIBILITY DOCUMENTATION REQUIREMENTS:

Proof of Residency:

Only one of the following, in your name (copies)

- Current lease
- Mortgage
- Utility Bill (Gas, Electricity, and/or Water Bill, Telephone bill (land line).
- Homeless individuals must provide letter from organization/shelter.
- A notarized letter from landlord or leaseholder.

Identification Requirements:

Only one of the following: (copies)

- Maryland ID/Driver's License.
- Passport, residency card, work authorization card
- Identification of Casa of Maryland

Income Requirements: (Household Income copies)

- Signed Tax Return (not more than 12 months old)
- W-2 Statement (not more than 12 months old)
- Paycheck or Stub with full name (Last 4 weeks)
- Letter from current employer on letter head of company stating gross income paid per week/month/year. If you are a contractor or sub-contractor, provide a notarized letter from employer stating gross income paid per week/month/year.
- Other proof of income (government/public benefits such as SSI award letter, disability, unemployment statement, child support, etc.)
- Statement letter from shelter or soup kitchen confirming homeless and indigence

Referring Agency Name: _____

Case Worker/Screeners: _____

Address: _____

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