MONTGOMERY COUNTY ADULT DENTAL PROGRAM APPLICATION
(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 PAY A FLAT FEE
$20.00 PER ROUTINE VISIT
$30.00 PER EMERGENCY VISIT

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: _____

Case Number: _____

Please complete the following application and provide copies of the documents listed on the 2nd page displaying applicant's name and current home address

Head of Household Name (Last, First, Middle)	Home Telephone	Work Telephone	Cell Telephone

Where Do You Live? (Number and Street)	Apt. #	City	State	Zip Code

What language do you speak? ☐ English ☐ Spanish ☐ Other:_____ Will you need language assistance? ☐ Yes ☐ No If yes, what language? _____

Are you or anyone in your household pregnant? ☐ Yes ☐ No If yes, who?_____ Due Date:_____

Are you Head of Household? ☐ Yes ☐ No If no, what is the name of the Head of Household? _____
(Have family members who depend on your income)

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

Are you a Montgomery Cares patient? *(Mercy Clinic, Proyecto Salud, Holy Cross, Spanish Catholic, Community Clinic, etc.)* ☐ Yes ☐ No

Are you or any of your family members participants of any of the programs listed below? ☐ Yes ☐ No

- Care for Kids
- Maternity Partnership
- Senior Dental Program

If you, what is the expiration date: _____

SECTION A. APPLICANT

Fill in the blanks for yourself and spouse/partner. Check YES for each person you are applying for. Check NO for each person you are not applying for.

Please complete for each person who has a Social Security number

APPLYING FOR: **ADULT DENTAL PROGRAM** (Must be between 19 to 59 years of age)	**NAME** (Last, First, Middle)	**RELATION TO YOU:**	**DATE OF BIRTH** (MM/DD/YYY)	**GENDER** M=Male F=Female T=Transgender Q-Genderqueer N-Non-Binary D=Decline Answer	**MARITAL STATUS** M=Married S=Single D=Divorced P=Separated W=Widowed	**RACE** A=Asian B=Black/African American C=White N=American Indian Or Alaska Native P=Native Hawaiian Or Pacific Islander	**ETHNICITY** H/L= Hispanic N/L= Non-Hispanic/ Non-Latino	**SOCIAL SECURITY NUMBER** (SSN)
☐ Yes ☐ No		**Self**					**☐ H/L ☐ N/L**	
☐ Yes ☐ No		**Spouse/ Partner**					**☐ H/L ☐ N/L**	

***You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.**

SECTION B. INCOME

Source of income: _____Total $ _____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Food Stamps (if applicable): $ _____ Unemployment Benefits (if applicable): $ _____ SSI or Disability Benefits: (if applicable): $ _____

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

Are you a student? ☐ Yes ☐ No If yes, check one: ☐ Full-time ☐ Part-time

If you do not have any income, please explain: _____

SECTION C. ADDITIONAL INFORMATION

Name (Last, First, Middle) Self	Country of Birth	Do you have Dental insurance ☐ Yes ☐ No If yes, is it: ☐ Private-Payer ☐ Employer-Based Name of Insurance: _____ID#_____
Name (Last, First, Middle) Spouse/Partner	Country of Birth	Do you have Health insurance ☐ Yes ☐ No If yes, is it: ☐ Private-Payer ☐ Employer-Based Name of Insurance: _____ID#_____

ELIGIBILITY DOCUMENTATION REQUIREMENTS:

Proof that you live in Montgomery County:
One of the following items, in your name (copies only)

- ☐ Current lease
- ☐ Mortgage
- ☐ Utility Bill (Gas, Electric, and or Water, Telephone Bill (Landline))
- ☐ Homeless individuals must provide letter from organization/shelter
- ☐ A notarized letter from landlord or leaseholder

Identification Requirements:
One of the following: (copies only)

- ☐ Maryland ID/Driver's License
- ☐ Passport, residency card, work authorization card
- ☐ Identification of Casa of Maryland
- ☐ Student ID (Must be current semester/year)

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 (not more than 30 days old)
- ☐ Letter from current employer on letterhead of company stating the gross income paid per week/month/year
- ☐ If you are a contractor or subcontractor, provide a notarized letter from employer stating gross income paid per week/month/year
- ☐ Other proof of income (government/public assistance benefits such as SSI award letter, disability, unemployment statement, child support, etc.)
- ☐ Statement/letter from shelter or soup kitchen confirming homeless and indigence

SUBMIT THIS FORM WITH ALL REQUIRED DOCUMENTS TO:

Please allow 2-3 weeks for applications to be processed. Once your application is processed, you will receive a letter with the outcome.

By Email:
hhsdentalmailbox@montgomerycountymd.gov

In Person:

Germantown Dental Services
12900 Middlebrook Drive, 2nd Floor
Germantown, Maryland 20874

Silver Spring Dental Services
8630 Fenton Street, 10th Floor
Silver Spring, Maryland 20910

Metropolitan Court Dental Services
7-1 Metropolitan Court
Gaithersburg, Maryland 20878

Rockville Pike Dental Services
1401 Rockville Pike, Suite 340
Rockville, Maryland 20852

By Mail:
Rockville Pike Dental Services Attn: Adult Eligibility
1401 Rockville Pike, Ste 340
Rockville, Maryland 20852

SECTION C. SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date