MONTGOMERY COUNTY ADULT DENTAL PROGRAM
SLIDING FEE SCALE APPLICATION (AGE 19 TO 59)

General and emergency dental services is provided to eligible uninsured and underinsured residents.
Patients in need of specialty dental care are given information for appropriate resources for follow-up care.

ALL APPROVED PATIENTS MUST PAY FEES DETERMINED BY THE MARYLAND DEPARTMENT OF HEALTH ABILITY TO PAY SCHEDULE

COUNTY OFFICIAL USE ONLY:
eICM Contact ID:
Case Number:

Please complete the following application if you are uninsured 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 in any of the programs listed below? ☐ Yes ☐ No

- Care for Kids
- Maternity Partnership
- Senior Dental Program

If so, 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: SLIDING FEE SCALE	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

DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

CLIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Department's *Notice of Privacy Practices*:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Client	Date of Birth	Signature of Client/Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the department may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the DHHS will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Name	Relationship	Address, or DOB, or Telephone #

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the DHHS make all communications to me by the alternative means or locations that I have listed below.

Home Telephone Number:

☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Written Communication Address:

☐ OK to mail to address listed above
☐ E-mail me at:

Mobile/Cell Telephone Number:

☐ OK to Text message with detailed information
☐ Leave message with call back numbers only

Fax Communication:

☐ OK to Fax at the number listed above
☐ E-mail me at:

Work Telephone Number:

☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Other:

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Department.

2. These Authorizations may be revoked at any time by notifying the Department in writing at the Departments mailing address marked to the attention of "HIPAA Privacy Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Name of Client (Printed) Signature of Client Date