



Campbell County Dental Assistance Program

Program Overview

PROGRAM HOURS:

Monday 1PM to 4PM and Thursday 9AM to 12 noon

ELIGIBILITY:

Campbell County residents who fall at or below the following income guidelines:

Monthly Income Guidelines (before taxes)

Family Size	1	2	3	4	5	6	7
Income Limit	\$1,814.54	\$2,455.88	\$3,097.21	\$3,738.54	\$4,379.88	\$5,021.21	\$5,662.54

APPLICATION PROCESS:

Program hours are Monday afternoons 1PM to 4PM and Thursday mornings 9AM to 12 noon. Applications are available at the front desk of the Campbell County Fiscal Court. Completed applications and documentation will only be accepted during program hours.

The following documentation is required before services will be scheduled:

- Photo ID
- Proof of Campbell County residency (60 days or longer)—utility bill, for example
- Proof of **entire household** income—two most recent paystubs or tax return, public benefit award letters

Please keep this page for your records.



Campbell County Dental Assistance Program

Participant Rules

Dental Assistance Program Participants are required to adhere to the following rules. Failure by a Participant to adhere to these rules may result in dismissal from the Dental Assistance Program.

1. Participants must be at all appointments and on time for all appointments.
2. Participants must give at least 48 hours' notice to the dental office if you cannot keep your dental appointment. Excessive cancellations may also result in dismissal from the program.
3. Once treatment is finished, your eligibility in the program is over. You must reapply or update documentation for future dental needs.
4. Participants must treat the dental office staff with respect. No disrespectful behavior will be tolerated.
5. Participants must follow through with treatment once a participant has been matched with a dentist.
6. Participants may not delay treatment except for personal illness.
7. Participants must notify the Program Manager for the following reasons:
 - a. Any changes in address or phone number
 - b. If you must delay or stop treatment
 - c. If you are referred to a specialist
8. Annual assistance (Fiscal Year July 1 – June 30) may not exceed \$1,500.00 per client. Any amount that exceeds this will be the responsibility of the client and is due to the dental provider **before** services will be delivered.

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APPLICATION FOR THE CAMPBELL COUNTY DENTAL ASSISTANCE PROGRAM

APPLICANT INFORMATION				
Name	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Address	City	State	Zip	
<input type="checkbox"/> Rent <input type="checkbox"/> Own				
Phone () _____	Social Security # _____ - _____ - _____			
Race (please circle):				
<input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Island <input type="checkbox"/> Asian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Black/African-American <input type="checkbox"/> White <input type="checkbox"/> Other				
Ethnicity (please circle):				
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> NOT Hispanic/Latino <input type="checkbox"/> Unknown/Not Reported				
Marital Status (please circle):				
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Other				
EMPLOYMENT				
Employer	Employer Address	City	State	Zip
Are you able to work? If no, please explain.				
LAST DENTIST SEEN				
Name	Approximate Date of last visit			
EMERGENCY CONTACT INFORMATION				
Name	Relationship	Phone Number		
INSURANCE INFORMATION				
Do you have Medicare?	Yes	No		
Do you have Medicaid?	Yes	No		
Do you have dental insurance?	Yes	No		

Household Members Please list ALL members of your household and any income, if applicable.				
Name	Age	Relationship to you	Monthly Amount	Source of Income/ Public Assistance
		Self		
Total Household Income Before Taxes			/ Month	
How did you hear about the Campbell County Dental Assistance Program?				
Services Needed (please circle all): Cleaning Extractions Fillings Dentures Partial Other:				

Signature _____ Date _____



Campbell County Dental Assistance Program

Authorized Consent Form

Please read and initial each of the following statements. After reviewing and agreeing to each of the conditions, please sign and date the form at the bottom.

_____ I understand that goal of the Campbell County Dental Assistance Program is to prevent dental decay and to restore participants to good oral health.

_____ I agree to follow the Campbell County Dental Assistance Program Participant Rules and that failure to follow those rules will result in dismissal from the Program

_____ I understand that the dentist determines the treatment plan to accomplish the goal of preventing dental decay and restoring the participant to good oral health. As such, the dentist is solely responsible for diagnosis and treatment.

_____ I agree to provide personal information that includes medical, dental and financial information.

_____ I give my consent for the referral coordinator to obtain information relevant to my eligibility for the Campbell County Dental Assistance Program. This information may come from, but is not limited to, physicians, dentists, financial institutions, and government or private agencies.

_____ I give my consent for the referral coordinator to share pertinent information, including but not limited to, my medical conditions, medical history and financial information with one or more participating dentists and their office personnel.

_____ I agree to hold harmless the Campbell County Dental Assistance Program and Campbell County Fiscal Court, for the release of my information to third parties.

_____ I understand that application to the Dental Assistance Program does not assure that I am eligible for services and as such I may not be referred to a dentist for an examination or I may not be accepted as a patient following an examination.

_____ I understand that participating dental providers are not obligated to provide donated or free services or care in the future or to maintain me as a patient.

_____ I understand and give consent to the Campbell County Dental Assistance Program to use my demographic information for marketing campaigns to promote involvement from dental professionals and potential funders.

_____ I agree that to the best of my knowledge the information I provided on this application is a full and accurate disclosure of my current financial status.

_____ I understand that the Dental Program depends upon outside funding sources. Any changes in funding may result in a disruption of my treatment. Accordingly, I agree to hold harmless the Campbell County Dental Assistance Program and the Campbell County Fiscal Court for any disruptions in my treatment.

_____ I understand that the Campbell County Dental Assistance Program may terminate my participation for any reason at any time.

_____ I understand that annual assistance (measured yearly from July 1 through June 30) provided to me may not exceed \$1,500.00 and that any amount that exceeds this will be responsibility of the client. I further understand that amounts in excess are due to the dental provider before services will be delivered.

Read, agreed and signed this _____ day of _____, 20____.

Sign: _____

Sign: _____

Client Name: _____

Guardian Name (if necessary): _____