APPLICATION FOR DENTAL SERVICES

Lincoln-Lancaster County Health Department
Dental Division
3131 O Street, Lincoln, NE 68510

Person applying for Dental Services _____

Relationship to patient _____

Social Security Number of Person Applying for Dental Services _____-_____-_____

Address (Number, Street) _____

City/State _____

Zip Code _____

County _____

Home Phone _____

Cell Phone _____

Email Address _____

Can we contact you by email or text message for appointment reminders? ☐ Yes ☐ No

Household Income: Hourly Weekly Bi-Weekly Monthly Bi-Monthly Annually Other

List All Household Members With Income	**Current Employer/Phone**	**Hourly Wage**	**# of Hours worked per week**	**Gross Monthly Income**	**How often paid: Use categories Above**
1.					
2.					
3.					
4.					

Do <u>you or anyone within your household</u> receive any of the following? **Amount**

1. Unemployment $_____
2. Social Security $_____
3. Disability Benefits $_____
4. Child Support/Alimony $_____
5. Retirement Benefits $_____
6. Supplemental Income from any other source (family, sponsorship, etc.) $_____
7. Household Income/Resources not previously identified $_____

Are you a U.S. citizen? ☐ Yes ☐ No

If not, what is your residency status? _____

Are you a current resident of Lincoln or Lancaster County? ☐ Yes ☐ No

How long? _____

What is your primary language? _____

Country of Origin _____

Do you need an interpreter for dental services? ☐ Yes ☐ No

Interpreter's Name: _____

Is the parent/or applicant applying for dental services a student? ☐ Yes ☐ No

Name of School_____

Is your spouse a student? ☐ Yes ☐ No

Name of School_____

-OVER-

HEALTH OR DENTAL COVERAGE		Insurance Company	Family members covered by the programs
Do you or anyone within your household receive Medicaid, Kids Connection, or Aid to Dependent Children?	___ Yes ___ No		
Are you or your family covered by Health Insurance?	___ Yes ___ No		
Are you or your family covered by Dental Insurance?	___ Yes ___ No		

LIST ALL MEMBERS IN HOUSEHOLD

Name	Relationship	Date of Birth	Age	Race (Use list below) □	Hispanic/Latina Ethnicity	Medicaid Number
1.					___ Yes ___ No	
2.					___ Yes ___ No	
3.					___ Yes ___ No	
4.					___ Yes ___ No	
5.					___ Yes ___ No	
6.					___ Yes ___ No	
7.					___ Yes ___ No	
8.					___ Yes ___ No	
9.					___ Yes ___ No	
10.					___ Yes ___ No	

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Native American ☐ Hawaiian/Pacific Islander ☐ Other

Immediate Health Concerns or Problems

_____

_____

Other Comments

_____

_____

I declare that the above information is complete and accurate. I understand that any information falsely reported can result in a re-evaluation of eligibility for services and possible dismissal from the dental clinic.

Print Name _____ Signature _____ Date _____

For Office Use Only:

Total Yearly Gross Income Reported for Household $_____ Client Fee Step_____

Staff Comments_____

_____