



STRATFORD HEALTH DEPARTMENT
468 Birdseye Street
Stratford, CT 06615-6905
(203) 385-4090

APPLICATION FOR DENTAL CLINIC ELIGIBILITY

The School Dental Clinic of the Town of Stratford was established for families that are in need of assistance to provide necessary dental care for their children. Eligibility for the program is determined on a need basis.

In order to help us determine this need, you are asked to provide the following information. You will be notified of the status of your application once verification of the information stated hereon is completed. Please be aware that if you and/or your spouse are employed, we must contact your employer(s) to verify your reported income. You may rest assured that all information will be treated in a confidential manner.

	<u>NAMES OF PUPILS</u>	<u>SCHOOL</u>	<u>D.O.B.</u>
1.			
2.			
3.			
4.			
5.			

A. List members of family who are employed, their place and address of employment (If unemployed, please indicate such and give last place of employment).

Name	Name & Address of Employer	Monthly Gross Income
Father:		
Mother:		
Other:		

B. Are you receiving child support? Yes No **If yes, monthly income: \$_____**

C. Please list members of your family living at home, including ages of children and their social security number.

	Name	Age	Social Security #
1.			
2.			
3.			
4.			
5.			
6.			

D. Is the father a veteran? Yes No

E. Are you receiving Aid to Families with Dependent children? Yes No

F. Are you enrolled in a Medicaid Managed Care Organization? Yes No

a. If yes, please indicate your Managed Care Plan:

- Blue Care Family Plan
- Community Health Network
- Health Net
- Preferred One

b. Subscriber Identification Number: _____

G. Do you have any other form of dental insurance? Yes No

a. If yes, what is the name of your insurance company? _____

b. Policy Holder and Number: _____

H. In your opinion, what is the reason you need assistance to obtain dental care for your child? _____

In the event that eligibility is granted:

I hereby authorize the Health Department Dental Clinic to do whatever reparative work, with or without a local or general anesthetic, that appears necessary for (Names of all children):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

I will pay the established fee required for each clinic session to the best of my ability. Permission is also given to verify any statement contained in this application.

Parent's Signature

Date

Home Address

() _____

City, State, Zip Code

Home Telephone

PLEASE MAIL THIS FORM IN A SEALED ENVELOPE TO:

Stratford Health Department
468 Birdseye Street
Stratford, CT 06615-6905

FOR OFFICE USE ONLY:

Denied

Approved:

Class #1

Class #2

Lisa Pippa, Director of Health

Date