**Nelson Unity In Community**

**Application for Adult Dental Assistance**

**Date**  \_\_\_\_\_\_\_\_\_\_ **Referred by**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Numbe**r \_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information**

**Name**:

**Address**:

Street City State Zip code

**Phone**: Home Work Cell

Preferred contact number: May we leave a message? Yes No

**Gender**: Male \_\_\_\_\_\_Female Date of Birth (mm/dd/yyyy)

**Race/Ethnicity**: Black/African American White \_\_\_\_\_Hispanic/Latino \_ Other or Mixed

**Marital Status**: Married Single Separated Divorced Widow(er)

**Housing Status**: Rent Own Share Homeless Shelter

**Type of Transportation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status**: Not Working Part-Time Full-Time Seasonal Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our organization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Information**

**Do you have a regular dentist?**

\_\_\_\_\_\_ Yes Dentist’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a patient at Blue Ridge Dental Center please add UIC’s name to your list for sharing

information so that we may discuss your dental needs and treatment plan with them.

If a dental plan has been made, please submit a copy with your application.

**\_\_\_\_\_\_\_\_** No Where have you had dental work done before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last dental visit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have dental insurance?** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what is your insurance company? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of dental work do you need?**

\_\_\_\_\_\_ Cleaning \_\_\_\_\_\_ Fillings \_\_\_\_\_\_ Teeth pulled \_\_\_\_\_\_ Other (Explain below)

\_\_\_\_\_ Dentures ( What dental work is needed before you are ready to get dentures? Explain below.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Household Financial Information

|  |  |  |
| --- | --- | --- |
| **Monthly Income of all in household Household** | **Additional Resources** | **Monthly Expenses** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Earned #1 |  | Food Stamps |  | Rent |  |
| Earned #2 |  | W.I.C. |  | Food |  |
| SSI |  | Fuel Assistance |  | Electric |  |
| SSA |  | Rent/Mortgage Aid |  | Gas/Fuel Oil |  |
| TANF |  | Tax Relief |  | Water/Sewer |  |
| Pension |  | Food Bank |  | Phone |  |
| Disability |  | Medicare |  | Car |  |
| VA |  | Medicaid |  | TV |  |
| Unemployment |  |  |  | Day Care |  |
| Other |  |  |  | Medical |  |
| **Total Income** |  |  |  | Clothing |  |
| If there is no income, explain how bills are being paid and who is paying them. |  |  |  | Laundry |  |
|  |  |  |  | Insurance |  |
|  |  |  |  | Credit Card |  |
|  |  |  |  | Miscellaneous |  |
|  |  |  |  | **Total Expenses** |  |

The information I have provided is true to the best of my knowledge. I give permission to UIC to share information with other individuals or organizations that may be able to help.

Signature \_\_ Date

Mail Completed Application to: Nelson Unity in Community or Email to: nelsonuic@gmail.com

P.O. Box 55 Phone: 434-277-8842

Roseland, VA 22967

**Dental Committee Use Only:**

Date of Initial Interview/Visit:

Information Taken By: Reviewed By:

Action Taken: Dentist and dental work to be done.

Financial Assistance Approved

Amount: $

Patient to repay- Amount: $ \_\_\_\_\_\_\_\_\_\_

Referred to: Request Denied - Reason

Signed: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_