ANNE ARUNDEL DENTAL ACCESS PROGRAM
ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH

APPLICATION

The Anne Arundel Dental Access Program (AADAP) is a program through which local dentists volunteer to provide dental services in their private offices at a reduced fee to people who have no dental insurance. Eligibility to this program is based on the total income of the household, assets owned by the household and the household size. Applicants must live in Anne Arundel County.

Patients are interviewed, via this form, by the Dental Program for eligibility. If eligible, you will receive a "fee reduction card" that is good for one year, along with a list of participating dentists. AADAP is NOT an insurance policy and does not provide insurance coverage. Members are responsible for all dental care costs.

Please complete **all** of the following information and enclose one copy each of your most recent **proof of income** (one month's pay stubs, unemployment compensation, pensions, disability, child support, alimony, Social Security, self-employment earnings for business, or a current signed, complete Federal Income Tax Form). If you do not have any income, you must let us know exactly how you pay your living expenses. **Proof of residency** must include a copy of your driver's license or a utility bill.

Last Name: _____ First Name: _____ M.I. _____

Residence Address: _____ Apt. or Floor # _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ # People in Household _____

Household

Please list everyone in your household (including yourself). Please mark whether you would like to apply for a card for other people in your family.

Are you applying for this person?	Name	Relationship to you	Date of Birth	Sex
Y N		**Self**		
Y N				
Y N				
Y N				
Y N				

Income Information

List any employer wages, earning, or money from a job or money from self-employment that you, your spouse or others listed above receive **(attach a copy of income documentation)**.

Name of Employed Person	Name of Employer	Address of Employer	Work Telephone Number	Gross Amount	Frequency (wkly/bi-wkly)	Begin Date
				Total:		

Other Resources
List any alimony, child support, pension, social security, rental income, retirement, strike benefits, unemployment, veterans, workers compensation benefits that you, your spouse or others in your household may receive (attach copy of income documentation).

Person Receiving Benefit	Type of Benefit	Amount Received	How Often?

Insurance Coverage History
Are you or any one applying for the ADDAP Program covered by any type of dental insurance? _____Yes _____No

Are you or any family member seeing a general dentist regularly? _____Yes _____No

If so, list family member and dentist's name _____

What type of dental care do you need now? _____

Applicant's Signature: _____ **Date:** _____

Confidentiality and Release of Information

I agree to the release of personal and financial information from this application form to the agency determining eligibility for the AADAP Program (Anne Arundel Dental Health Program) so that they can evaluate it and verify eligibility. I understand that I may be asked to provide additional information. Officials of the AADAP Program may verify all information on this form. I understand that I must tell the agency that determines my eligibility about any changes in information on this form. By signing this application, I certify under penalty of perjury that everything on this form is the truth.

I certify under penalty of perjury that all applicants for the AADAP Program are residents of Anne Arundel County and have no dental insurance.

All information and documentation gathered for determining eligibility is confidential. Disclosure of information concerning my eligibility to anyone not authorized to receive this information is a violation of State and Federal Laws.

The application must be signed by a household member 19 years of age or older.

_____ _____
Signature of Applicant Date

Please return this application with a copy your most recent proof of income and residency to:

Anne Arundel County Department of Health
Dental Health Program, HD #6
3 Harry S. Truman Parkway
Annapolis, Maryland 21401
Phone: 410-222-7138 FAX: 410-222-4070

Checklist before returning application (*Please include one each for Residency and Income****):***

_____ **Proof of Residence (send 1):**
Driver's license or other identification card _____ BGE (Energy) Bill _____ Lease/Mortgage Contract _____

_____ **Proof of Income (send 1):**
One month's pay stub_____ Unemployment compensation statements_____ Disability statement _____ Pension statement __
Child Support statements_____ Alimony statements_____ Social Security statements_____ Food stamp statements_____ Self-employment earnings for business (most current signed and dated Federal Income Tax Return, including profit/loss tax form) _____
Current signed Federal Income Tax Form_____ If no income, explanation of how living expenses are paid

*"AADAP" patients **under the age of 21** **may be eligible** for services at one of the dental clinics of the Anne Arundel County Department of Health. These services are provided on a sliding fee scale. No patient is denied services due to inability to pay. If you would like more information, or have questions as to whether you qualify for this program, please call the Dental Program at 410-222-7138 or 410-222-6861.*

Dental/Revised 5/2009

Please do not write below this line – Office use only
Fee Reduction_____% Date Issued:_____ Interviewer:_____