APPLICATION FOR DENTAL SERVICES
Lincoln-Lancaster County Health Department
Dental Division
3131 O Street, Lincoln, NE 68510

Person Completing Application ______________________________

Relationship to Patient(s) ________________________

Social Security Number of Person Completing Application _______-_______-_________

Address (Number, Street) ______________________________

City/State ____________________

Zip Code _________

County _______________

Home Phone _______________

Cell Phone _________________

Email Address ____

How would you like to be contacted for appointment reminders? ☐ **Phone** ☐ **Text** ☐ **Email**

List All Household Members with Income	Current Employer/Phone	Hourly Wage	# of Hours worked per week	Gross Monthly Income	How often do you get paid: (Hourly, Weekly, Bi-Weekly, Monthly, or Annually)
1.					
2.					
3.					
4.					

Do you or anyone within your household 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 college or graduate student? ☐ Yes ☐ No

Name of School_____________________________________

Is your spouse a college or graduate student? ☐ Yes ☐ No

Name of School_____________________________________

-OVER-

Is the parent/or applicant on a visiting or student visa? ☐ Yes ☐ No

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____
____

Revised 6/2024