Revised 08/2018

NORTHERN KENTUCKY ADULT DENTAL ASSISTANCE PROGRAM APPLICATION

APPLICANT		
Name	**Date of Birth**	**____ Male** **____ Female**
Address _____ _____	**City**	**Zip**
Phone **( ) _____** **( ) _____**	**Social Security #** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	

Race/Ethnicity (check all)

- ○ **American Indian or Alaskan Native**
- ○ **Asian**
- ○ **Black or African-American**
- ○ **Hispanic or Latino**
- ○ **Multiracial**
- ○ **Native Hawaiian or Pacific Islander**
- ○ **White**

County of Residence:

☐ **Boone** ☐ **Campbell** ☐ **Kenton**

LAST DENTIST SEEN	
Name	**Approximate Date of last visit**

EMERGENCY CONTACT		
Name	**Relationship**	**Phone Number**

INSURANCE			
Do you have dental coverage?	**Yes**	**No**	**Unsure**
Do you have Medicare?	**Yes**	**No**	**Unsure**
Do you have Medicaid?	**Yes**	**No**	**Unsure**

EMAIL

_____

HOUSEHOLD

Please list ALL members of your household (including self) and ALL sources of income for each person: Wages, Unemployment, Social Security, KTAP, Child Support, etc.

Name	Age	Relationship to you	Monthly Income Before Taxes	Source(s) of Income/ Public Assistance
1.				
2.				
3.				
4.				
5.				
6.				
7.				
Total Household Income <u>Before</u> Taxes			**/ Month**	

Services Needed (check all):

- ○ **Cleaning**
- ○ **Extractions**
- ○ **Fillings**
- ○ **Denture(s)**
- ○ **Partial(s)**
- ○ **Unsure**

Other:

How did you hear about the NKY Adult Dental Assistance Program?

Have you received assistance from the NKY Adult Dental Program in the past?

____ **Yes**

____ **No**

By signing below, you are certifying that the information provided in this application is true to the best of your knowledge.

Signature _____ Date _____