



**NORTHERN KENTUCKY ADULT DENTAL ASSISTANCE PROGRAM APPLICATION**

Today's Date: \_\_\_\_\_

APPLICANT			
Name		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____ _____		City	Zip
Phone (     ) _____ (     ) _____		Social Security # ____ - ____ - _____	
<b>Race/Ethnicity (check all)</b> <input type="radio"/> American Indian or Alaskan Native <input type="radio"/> Multiracial <input type="radio"/> Asian <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> Black or African-American <input type="radio"/> White <input type="radio"/> Hispanic or Latino			
<b>County of Residence:</b> <input type="checkbox"/> Boone <input type="checkbox"/> Campbell <input type="checkbox"/> 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			
_____			

<b>HOUSEHOLD</b>				
<b>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.</b>				
<b>Name</b>	<b>Age</b>	<b>Relationship to you</b>	<b>Monthly Income Before Taxes</b>	<b>Source(s) of Income/ Public Assistance</b>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
<b>Total Household Income <u>Before</u> Taxes</b>			<b>/ Month</b>	
<b>Services Needed (check all):</b> <input type="radio"/> <b>Cleaning</b> <span style="margin-left: 300px;"><input type="radio"/> <b>Partial(s)</b></span> <input type="radio"/> <b>Extractions</b> <span style="margin-left: 300px;"><input type="radio"/> <b>Unsure</b></span> <input type="radio"/> <b>Fillings</b> <span style="margin-left: 150px;"><b>Other:</b></span> <input type="radio"/> <b>Denture(s)</b>				
<b>How did you hear about the NKY Adult Dental Assistance Program?</b>  				
<b>Have you received assistance from the NKY Adult Dental Program in the past?</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>				

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

Signature \_\_\_\_\_ Date \_\_\_\_\_