Mabel T. Caverly Senior Services

A friendly place providing stepping stones over deep water
911 W. 8th Avenue, Suite 104
Anchorage AK 99501-3340
Phone: 907-276-1496 Fax 907-258-1356

DEAP DENTAL APPLICATION

Anchorage Bowl _____ **Mat-Su Borough_____**

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Micro grant for dental work (__), **Work already begun will not be eligible under this grant.**

Date_____
How or from whom did you hear about the program? _____
Name of Applicant (please print)_____
Male_____Female_____ Date of birth_____ Age_____
Address_____
City_____ Zip_____

Attach proof of residency such as driver's license and utility bill, etc.
ID#_____ Phone#_____
Contact Name (if other than applicant)_____ Phone #: _____
Number of persons residing in household_____ADULTS_____; CHILDREN UNDER 18_____
Do you have: Health insurance (circle one) ____yes_____no
Medicaid (or CHOICE waiver) (circle one) _____yes_____no
Previous applicant?____ yes_____no Date:_____
Previously approved?_____yes_____no Date:_____
Do you have any other assistance for DEAP dental services? _____yes_____no
Name of other source or sources_____

ATTACH PROOF OF INCOME

Total **HOUSEHOLD*** INCOME (If your income is the same every month, you need only put down one month's income; otherwise provide most recent 3 month's of wages and divide by 3).

Wages _____
Social Security _____
Pension _____
Senior Benefit _____
Disability payments _____
Unemployment compensation_____
Alimony or spousal support _____
Other _____
TOTAL per month $_____

***Note: Household income is total for all people living with you.**

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Total previous three (3) months' out-of-pocket medical, dental, hearing, vision expenses (good faith estimate):

Physician _____
Lab _____
Prescription _____
Dentist _____
Eyeglasses _____
Hearing Aid _____
Other _____

TOTAL _____
DIVIDED BY 3 = _____PER MONTH

Own home_____Rent_____
Amount of mortgage or rent per month _____
Does above include utilities? ____yes _____no Cable?____yes_____no
Besides your current place of residence, do you own:
Cabin? ___yes___no; Condominium?__yes___no; Timeshare?__yes__no
How many working vehicles do you own?___ Make and year of each_____
Do you own:
RV? ___yes___no; Camper ___yes____no; Boat___yes___no; Snowmachine/ATV____yes____no

Do you have a checking account?_____Yes_____No; Savings account?_____Yes _____No
Name of financial institution(s) _____
_____
_____
Current checking account(s) balance(s) _____

Current savings account(s) balance(s) (include certificates of deposits) _____

Current value of stocks, bonds, mutual funds, etc _____

Other information which you would like MTCSS to be aware of that might better help us understand your circumstances. For instance, you are supporting adult children or grandchildren, the cost of your anticipated dental work, the type of dental work required, if you have a toothache, you need your teeth fixed to get a job, etc.

_____
_____
_____
_____
_____
_____
_____

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Where do you get your **<u>health</u>** care**?** (check one or more)

I have a private practice medical provider (almost always go to the same health care provider)_____
I regularly use Anchorage Neighborhood Heallth for my primary care_____
I occasionally/usually use a walk-in storefront clinic._____
I go to the emergency room_____
VA_____
AK Native Medical Center_____
I don't go to a doctor or other healthcare provider._____

Where do you get your **<u>dental</u>** care? (check one or more)

I regularly go to a private practice dentist._____
I regularly use Anchorage Neighborhood Health Center_____
I go to UAA's hygienist school for cleanings, but otherwise don't get much dental care.____
VA_____; Other_____
AK Native Medical Center_____
I rarely get dental care._____
My last visit to a dentist was _____

Please note: If the information provided herein is found to not be materially accurate, then any approval will be immediately revoked and the applicant will be prohibited from reapplying for the DEAP program. <u>The program does not cover work already begun prior to our approval date.</u>

I hereby confirm that all the information contained herein is accurate to the best of my knowledge.

X_____ _____
Signature Date

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FOR STATISTICAL PURPOSES ONLY

Age_____M____F____ Are you a member of Mabel T. Caverly Senior Services?_____yes _____no
Would you like to become a member? _____ (Some scholarships are available)

Income range:

_____ less than $5,000 per year
_____ $5,000 - $9,999 per year
_____ $10,000 – 14,999 per year
_____ $15,000 - $20,000 per year
_____ $20,001 - $26,000 per year
_____ $26,001+

Circle one:

Alaska Native	Caucasian
Hispanic	Asian
Native American	African American
Other_____	

I am retired_____. A homemaker_____ Working less than 20 hours/week_____
Working 20-40 hours/week_____ Employed full-time_____ Looking/training for work_____
Other_____

I hereby authorize Mabel T. Caverly Senior Services to compile all information contained in this application **WITH THE EXCEPTION OF MY NAME, ADDRESS, PHONE NUMBER, AND SOCIAL SECURITY NUMBER** , in order to provide the statistical documentation necessary for the accurate reporting of the results of this program to grantors, and for use in future grant requests.

_____ _____
Printed Name Signature Date

IMPORTANT QUALIFYING INFORMATION ABOUT THE DEAP DENTAL ASSISTANCE PROGRAM

Acknowledge you have read the one-page explanation of the specific qualifications and guidelines of DEAP by signing the signature page below and returning it with your completed DEAP application.

Incomplete applications will not be processed.

Provide proof of income (bank statement, Medicare, Senior Benefits, etc.)

Provide proof you are an Anchorage-area or Mat-Su area resident. (Driver's License or ID)

This program is not available in combination with health insurance, Medicaid or other dental coverage.

Please see below for the funding parameters.

MICRO-GRANT FUNDING PARAMETERS AS OF 9/1/2015

Income limits **$2,166.00 per month for a single individual**
$3,000.00 per month for a married couple

No warranties, expressed or implied, are made as to the length of the DEAP program's existence.

Please sign below to confirm that you have read and understand the information contained herein:

I have read and understand the DEAP dental assistance program information and the information on page 4 above.

Print name_____ Date_____

Signature_____

Revised 9/9/2015