McDonough County Health Department
505 East Jackson
Macomb, IL 61455
309-837-9951

APPLICATION FOR COMMUNITY DENTAL ASSISTANCE PROGRAM

PLEASE READ PRIOR TO FILLING OUT THE APPLICATION

In order to apply to the Community Dental Assistance Program, the applicant must meet specific criteria. The criterion for application to this program includes providing proof of:

- No dental insurance coverage
- Income level lower than State of Illinois Eligibility Guidelines (see below)
- 18 years of age or older
- Ability to pay $50 to contribute to the expense of oral health services received, regardless of total cost
- Not receiving dental treatment for greater than 2 years
- Needing urgent dental care treatment (fillings and/or extractions)

State of Illinois
Income Eligibility Guidelines

Persons in Family or Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	$21,978	$1,832	$916	$846	$423
2	$29,637	$2,470	$1,235	$1,140	$570
3	$37,296	$3,108	$1,554	$1,435	$718
4	$44,955	$3,747	$1,874	$1,730	$865
5	$52,614	$4,385	$2,193	$2,024	$1,012
6	$60,273	$5,023	$2,512	$2,319	$1,160
7	$67,951	$5,663	$2,832	$2,614	$1,307
8	$75,647	$6,304	$3,152	$2,910	$1,455
Each additional family member add	+$7,696	+$642	+$321	+$296	+$148

The oral health services that would be provided would include emergency and urgent care services limited to fillings and extractions (dental exam and x-rays included) up to the amount of $500. The community dental outreach program will be ongoing with the application process starting in April 2017. Qualified applicants will be referred to the participating dental care providers within McDonough County to receive treatment in the form of extractions and/or fillings at the specific dental practice. The program will continue as funds allow. Applicants will be processed in a "first come, first served" manner. If accepted, you will be contacted by a health department staff member.

Please return completed application to the McDonough County Health Department

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Name: _____ Age: _____

Address: _____

Phone Number: _____

E-mail: _____

Please answer the following questions:

1. When was your last visit to the dentist? _____

2. What dental complications are you experiencing?
_____
_____

3. What is your monthly income?
_____

4. How will receiving financial assistance for dental treatment improve your health/life?
_____
_____
_____

5. Do you currently have a dental provider? If so, who?
_____

Please check YES or NO to the following questions:

	YES	NO
Are you able to contribute $50 up front toward the cost of receiving dental treatment?		
Do you have dental insurance?		
Has it been longer than 2 years since you've seen the dentist?		
Are you 18 years of age or older?		
Would you be willing to share a personal story from participating in our community dental assistance program?		

I have read and understand the conditions of the Community Dental Assistance Program. I agree that if I am unable to make my scheduled appointment, I will call with at least 24 hours notice, prior to the scheduled appointment, to cancel with the dental provider. If I fail to do so, I understand my $50 deposit will be lost, and I am no longer eligible to participate or reapply to the program.

_____ _____

Signature Date

Please return completed application to the McDonough County Health Department