Bridges for Smiles Children's Dental Application

The Bridges for Smiles Children's Fund provides individuals with Dental assistance related to their health care needs. All other available avenues must be exhausted before an individual may be considered for assistance.

Name _____ **Date of Application** _____

Address:_____**City/State**_____**Zip**_____

Home Phone: _____**How did you hear about our fund:** _____

Who is your physician: _____ **Who is your dentist:**_____ **Date of your last visit at Physician:** _____**Dentist**_____

Describe your need: _____

Are you aware of the services provided by the Christian Medical Clinic? ❑ Yes ❑ No **Have you ever used their services?** ❑ Yes ❑ No

Are you aware of the services provided by the Christian HELP Center? ❑ Yes ❑ No **Have you ever used their services?** ❑ Yes ❑ No

***Please check <u>all</u> that apply*. I have or have applied for:** ❑ Medicaid ❑ Medicare ❑ Sooner Care ❑ CDIB Card

❑ Other state or federal assistance--application date: _____

Please list everyone that lives in the household (yourself first) and complete each space beside each name.

NAME: First, MI, Last	Relationship	Birthdate Mo/Da/Yr	Marital Status	Social Security Number

List everyone in the household that has <u>any</u> source of income-including child support, SSI, disability, unemployment etc.

Name of Person Receiving Income	Employers Name OR Source of Income	Position (if employed)	Take Home Income Per Pay Check	How Often Paid weekly, bi-weekly, monthly etc.

Please List all medical debts you owe

Debt (Specify Type)	To Whom Owed	Original Amount	Amount Now Owed	Monthly Payment

List other debts and expenses

❑ Own home – Mortgage Holder (*name):*	Balance:	Monthly Payment:
❑ Rent home – Landlord (name):	Phone:	Monthly Payment:
Automobile:	Balance:	Monthly Payment:
Automobile:	Balance:	Monthly Payment:
Automobile:	Balance:	Monthly Payment:
Please List Credit Card or Name of other Debtor Below:	**Balance**	**Monthly Payment**

Signatures – I certify that everything I have stated in this application and on any attachments is correct. By signing below I authorize you to check my employment history. I also authorize you to share and receive personal information including medical history as it pertains to the funding of this request. If more than one signs the Application, their liability shall be joint and several. I also consent to the release of all or part of my medical records and information by and between INTEGRIS Grove General Hospital or the Grove General Hospital Foundation and any hospital, pharmacy, physician, clinic or other medical agency in which I was or will be a patient/customer of.

For PIN/TCBF Board Use Only

Please list any special circumstances that should be taken into consideration with this applicant:

Notes:

❑ Approved _____ _____

_____ _____

❑ Denied – explanation _____