OFFICE USE ONLY: Approved? YES / NO
DATE: _____
INITIALS:

Lincoln County Dental

APPLICATION/DETERMINATION OF ELIGIBILITY FOR DENTAL SERVICES

Last Name: _____ First Name: _____ M.I. _____

Street: _____ City: _____ State: _____ Zip Code: _____

Best Phone #: _____ S.S.#: _____ Employer: _____

In order that we may verify income and family composition, please enclose a copy of your **MOST RECENT TAX RETURN**, together with any other qualified verification you might deem appropriate:

- Payroll Check Stubs
- W-2s
- 10-99s
- Social Security checks, etc.

PLEASE LIST FAMILY MEMBER'S NAME(S) AND BIRTHDATES BELOW:

Name	Relationship	Date of Birth

Total Family Size: _____ **Annual Household Income: $_____**

Upon the receipt of an application, Lincoln County Dental, Inc. shall determine that an individual seeking care qualifies for such care if:

(a) The individual meets the income guidelines
(b) Is a Lincoln County Resident
(c) The individual is not covered by insurance nor eligible for coverage by state or federal programs of medical assistance

*I certify that the above information is **true** and **accurate** to the best of my knowledge. Further, if any information I give proves to be untrue, I understand that Lincoln County Dental, Inc. has a right to disqualify me from seeking their services. I agree to pay the **discount fees** at Lincoln County Dental and **understand my insurance (if any) will NOT be utilized.***

Applicant Signature: _____ Date of Request: _____

Please return this application and all necessary attachments to
Lincoln County Dental, Inc. 748 Main Street, Damariscotta, ME 04543
Email: office@lcdental.org **Fax**: 1(866)336-7756