(Revised 2021) DATE_____

APPLICATION FOR DENTAL CARE ASSISTANCE

Orcas Island Community Foundation (OICF), San Juan County Health and Community Services (HCS), North Sound Accountable Communities of Health Local Impact Network (ACH LIN), Orcas Community Resource Center (OCRC), and Medical Teams International, are collaborating to provide dental care to Orcas residents. Scheduled 2021 Dental Van dates on Orcas are: April 14-17, May 10-13, September 22-25, and November 3- 6. All information provided in this form will be handled confidentially. Applicants with appointments will be contacted prior to the clinic. **Please note that completing this application does not guarantee an appointment**. Patients with the greatest need will be given priority. If you have any questions or require assistance with completing the form, please contact Kristen Rezabek, San Juan Co HCS kristenr@sanjuanco.com or call 360-370-7518.

COMPLETED applications are accepted at the Orcas Community Resource Center or Orcas Senior Center

Patient's Name:_____

Patient's Birth Date: _____Age: _____ Employer: _____

Parent or Guardian (if patient is a minor):_____

Address (mailing and physical, if different):_____

I have been seen on the dental van before: **YES** **NO**

Preferred method of contact: **Phone** **Text** **Email**

Best contact number: _____Alt. contact number:_____

May we text you? _____Email: (preferred)_____

Do you have dental insurance? YES NO

Please indicate (if known), what dental care you may require. Please number in order of priority from 1-5.

EXTRACTION _____

FILLING _____

CLEANING/EXAM _____

Last time teeth cleaned: 1 yr or less _____ 1-3 yrs _____ 5+ yrs_____10+_____

ARE YOU EXPERIENCING PAIN? _____ Level on a scale of 1-10_____

Please describe the pain/discomfort:

_____

_____

ANY SWELLING OR INFECTION? YES _____ NO_____

Last time you saw a dentist?_____

Are you **currently** receiving dental care or treatment? _____

Dentist:_____ Phone:_____

Health issues or concerns:_____

DENTAL VAN SCREENING GUIDELINES:
Individuals accepted for treatment on the dental van MUST 1) have incomes less than 200% of the federal poverty level (2021 chart below) 2) have no dental insurance of any kind, or cannot access dental care on your current insurance, and 3) have no realistic ability to pay for the urgent dental care they need.

Family Size	200% FPL
1	$25,760
2	$34,840
3	$43,920
4	$53,000
5	$62,080
6	$65,920
7	$80,240
8	$89,320

Total income from all sources for household:_____

If there are extenuating circumstances you would like us to consider, please describe:_____

_____

Location application was obtained (i.e. Food Bank, WIC, OCRC, library):_____

Do you need any special services? (i.e. translation)_____

Preferred day/time (are there any limitations to when you can be scheduled? i.e. work on Saturdays, etc). Clinics usually run from 8-3PM and we cannot guarantee that we can accommodate scheduling requests.

_____

I certify that that the information provided is true and complete to the best of my knowledge and that I do not have any insurance to cover these costs:

Signature:_____ Date:_____

OFFICE USE ONLY:
Date Application received:_____ Income guideline met: YES NO
Priority: I - PAIN/INFECTION
II - DECAY
III - PROPHY FMD

Scheduled clinic date:_____

Follow up care required:_____

Contacted patient (date and initials):