



MassDentists CARE Financial Form

Form fields for personal information: PARENT/GUARDIAN'S NAME, STREET ADDRESS, TOTAL NUMBER OF FAMILY MEMBERS, PARENT/GUARDIAN'S EMPLOYER, OCCUPATION/JOB TITLE, etc.

INCOME

Income section fields: PARENT/GUARDIAN'S MONTHLY INCOME, SPOUSE'S MONTHLY INCOME, RENTAL INCOME, OTHER INCOME

TOTAL MONTHLY HOUSEHOLD INCOME

EXPENSES

Expenses section fields: MONTHLY MORTGAGE/RENTAL PAYMENTS, MONTHLY UTILITIES, CREDIT CARDS, OTHER EXPENSES

TOTAL MONTHLY HOUSEHOLD EXPENSES

If you have MassHealth Dental Care, or have dental insurance, you are not eligible to apply for this program since MassHealth or your insurance will pay for your child's dental care.

I hereby certify that the above information is true. I understand that if my child(ren) is eligible for the program I am responsible for paying the fee for services provided by the dentist I select.

Applicant signature _____ Date _____

Spouse signature _____ Date _____

Complete information must be provided. Incomplete applications will not be processed.

Eligibility for "MassDentists CARE" expires after two years. Patients must complete a new application and be approved in order to remain in the program.

