Dental Clinic _____
New Applicant _____
Renewal _____
Last Visit _____

# DENTAL HEALTH SERVICES ELIGIBILITY APPLICATION

Form HCDS Rev. 01/16

Hawaii State Department of Health
Hospital & Community Dental Services Branch

**Applicant Name:** _____ (Last / First / M.I.) **Birthdate** ____/____/____ **Gender:** Male___ Female___

**Home Address:** _____ **City:** _____ **Zip:** _____

**Mailing Address:** _____ **City:** _____ **Zip:** _____

**Care Home/Foster Home Name** (If Applicable): _____

**Phone** (Home): _____ **Phone** (Cell): _____ **Phone** (Work): _____

**Legal Guardian** (If Applicable): _____ (Name / Agency / Relationship / Phone)

**Monthly Gross Income:** Include SS, SSI, SSDI, unemployment compensation, food stamps, alimony, contributions from family members, general assistance.

| Amount | Source |
|---|---|
| $ _____ | _____ |
| $ _____ | _____ |
| $ _____ | _____ |
| $ _____ | **Total** |

Checking $ _____
Savings $ _____
_____ (Year) Income Tax Information
Gross Income $_____

**Monthly Expenses** (Including rent): _____

**Dental Care Financing** (Check):

____ Self
____ Family
____ Medicaid
____ Insurance

Medicaid Recipient Hawaii ID: _____
Medicaid Recipient Name: _____

**Referral Source** (Check):

____ Self
____ DHS
____ Dentist
____ Physician
____ Family Friend
____ Other DOH Program
____ Community Agency
____ Other: _____

**Patient Category** (Check all that apply):

____ GAP
____ Medicaid
____ Mental Health
____ Intellectual/ Developmental Disabilities
____ Other
____ Homeless
____ Blind
____ Disabled
____ Aged (65 years and older)
____ Emergency Only

Eligibility is valid for 12 months from date of authorization.
A new application is to be submitted anytime there is a marked increase or decrease in family income.

**I hereby certify the above is true and correct to the best of my knowledge.**

**Signature:** _____ **Date:** _____

Relationship to Applicant: _____

Eligible _____ % Cost + Ineligible 100% Lab Fees
Authorized Signature _____ Date ____/____/____

Submitted by:
DOH Interviewer _____
Agency _____ Phone _____

Submit WHITE and YELLOW copies to: Hospital & Community Dental Services Branch - 1700 Lanakila Ave. Room 203 - Honolulu, HI 96817