New Hampshire DENTAL SOCIETY

603-225-5961
mwebber@nhds.org
23 So. State St. Conocrd, NH 03301

professional denture care program

Dear Applicant,

Thank you for your interest in the Professional Denture Care Program. Enclosed you will find an application which details the process of the program. This is not a free program. If you are accepted, dentures must be paid in full within 90 days of your acceptance letter. The cost is $700.00 per denture ($1400.00 for both). This program does not include partial or immediate dentures.

Please return the application WITH VERIFICATION OF ALL HOUSEHOLD INCOME (Income for all those living in the household) This includes copies of Social Security statements (DO NOT SEND A BANK STATEMENTS), employment stubs-4 consecutive weeks, Welfare, food stamps, child support, VA and /or retirement pensions, etc. Please send in a copy of your property taxes or rental/lease agreement.

If your application is received incomplete, it will be returned once for further documentation. You will have 60 days to re-submit that information or your application will be denied.

If you have any questions, please call the office at 603-225-5961. Office hours are Monday through Friday, 8:30am-4:30pm. I look forward to helping you get your smile back!

Warm regards,

Melissa Webber
mwebber@nhds.org
Administrative Coordinator

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Thank you for applying for the NHDS Professional Denture Care Program. Please note any application received without proper documentation will be returned.

YOUR INFORMATION

First Name

Last Name

Phone

Date Of Birth

E-mail

Address

Mailing Address if different

City

Zip Code

Case Manager or Sponsor's Name and Telephone:

Are you enrolled in any of the New Hampshire Department of Education Rehabilitation Programs?

○ YES ○ NO

If yes, which office of the Vocational Rehabilitation Program is handling your case?

HOUSING:

Do you: ○ own ○ rent ○ group home ○ other → please explain:

Monthly Amount of Mortgage or Rent:

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IF YOU OWN YOUR OWN HOME, PLEASE INCLUDE COPY OF PROPERTY TAX

IF YOU RENT, PLEASE INCLUDE CONTACT IFORMATION OF LANDLORD/RENTAL COMPANY*:

*Please include copy of Rental Agreement

Name of Landlord or Company

Phone

Email

Company Name

Company Phone

Service Applying For:

FIRST DENTURES:

○ upper ○ lower

REPLACEMENT DENTURES:

○ upper ○ lower

This program does NOT include extrations, partial dentures, immediate dentures or dental implants.

Do you require extractions?

○ yes

○ no

If you have had extractions within the last year, who paid for the extractions?

Do you have dental insurance?
if so, what company?

Your General Dentist's Name:

Do you require wheelchair accessibility?

○ yes ○ no

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EMPLOYMENT HISTORY

Employer Phone

Employer Name

Address

Job Title / Position

Employer Phone

If applicant is unemployed, please answer the following:

Reason for not being employed:

If Disabled, Please State Nature and Date of Disability:

Was Disability Incurred at Work?

○ yes ○ no

Date last employed:

Name & Address of Last Employer:

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HOUSEHOLD INCOME INFORMATION

Total number of people living in household:

Please list names, ages and relationship to applicant of ALL people living in household:

Please fill in the correct amounts below from all sources and for all people listed above. Use the gross income (before deductions).
SOURCES AND AMOUNTS OF INCOME: Indicate if paid weekly, monthly, or annually.
PLEASE INCLUDE COPIES OF ALL BENEFITS FOR ALL THOSE LIVING IN THE HOUSEHOLD WITH THIS APPLICATION. (Documentation will NOT be returned)

SOURCE OF INCOME / AMOUNT

Employment		State, Town, or City Welfare	
Social Security		Unemployment	
Child Support		Food Stamps	
Supplemental Security Income		Rental Assistance	
VA Benefits/ Retirement/ Pension			

TOTAL MONTHLY INCOME:

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PLEASE READ
Applicant should be aware that further documentation may be requested; if this information is not provided or the application is not fully completed, the application will be denied on that basis.

Applications will be returned ONCE.

- Assignment to a participating dentist is the responsibility of the New Hampshire Dental Society & may take 1-4 months.
- Any patients contacting a dentist for assignment for dentures will be disqualified from the program.

I SWEAR UNDER PENALTIES OF PERJURY THAT THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND THAT IF INFORMATION HAS BEEN FALSIFIED, I AM LIABLE FOR THE FULL COST OF SERVICES PROVIDED.

_____ _____

applicant / guardian signature (please send proof of guardianship

date