

**Return to:**  
 Kids in Need of Dentistry (303-733-3710 x 15)  
 2465 S. Downing, Suite 210  
 Denver, CO 80210

___	approved
___	percent
___	denied
___	initials

# KIND's CLINIC ELIGIBILITY APPLICATION

Please PRINT and fully complete this form or it will be returned.

Head of Household \_\_\_\_\_ Spouse \_\_\_\_\_

Additional Household Members (over age 18) \_\_\_\_\_

Total number of household members \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Has your child(ren) been seen at KIND Clinic before? (Yes or No) \_\_\_\_\_

Child's Name	Sex M/F	Birth Date	Medicaid	CHP+	Headstart	WIC	Social Security #

If your child has Medicaid, CHP+, Headstart or WIC you must send documentation as follows:

- copy of Medicaid card
- copy of CHP+ card
- copy of Headstart card and/or letter
- copy of WIC card and/or letter
- copy of Section 8 Housing benefits letter

If your child does not have any of the above assistance you must provide PROOF OF INCOME by sending **two** of the documents required as follows:

- recent pay stubs for two consecutive months
- copy of all W2's for jobs held during the most current year
- copy of tax return for the most current year
- letter from employer stating gross monthly income amount
- unemployment benefits documentation if unemployed at the time of application

You are also required to return this application with PROOF OF ADDITIONAL INCOME as follows:

- any additional income sources not listed above
- child support
- Social Security benefits
- Disability benefits

The information I have furnished is true and correct. I understand that withholding or falsification of any information on this form or the supportive documents may cause dismissal of family members from the Kids in Need of Dentistry program(s).

Signed \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*SEE OTHER SIDE\*\*\*\*\*

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**Please review the following Kids in Need of Dentistry (KIND) policies:**

**your application will not be processed until you sign**

**KIND's Financial Policy**

I understand that I am financially responsible for all services rendered to my child(ren) by KIND.

I understand that KIND accepts payment from both Medicaid and/or CHP+. If these benefits are terminated for any reason, I understand that any remaining unpaid balance is to be paid by me.

**KIND's Appointment Policy**

I understand that KIND requires a 24-hour notice when canceling an appointment.

I understand that KIND and the State Practice Act requires a parent (or legal guardian) present at the first visit.

I understand that KIND and the State Practice Act requires an adult to be present at all appointments. If appropriate, a parent (or legal guardian) may sign a form allowing another adult to be present for follow-up visits.

I understand that prepayments are nonrefundable for missed appointments or untimely cancellations.

I understand that prepayment is required before your child can be referred to a private dental office (if necessary).

I understand that completion of my child's treatment plan may require some distance travel from my home to KIND's various clinic locations. I understand that I am responsible for this travel to the available clinic. Further, I understand that failure to travel to the necessary KIND clinic requires me to find a resource other than KIND to complete my child's treatment plan.

I have read and agree to abide by KIND's Financial Policy and Appointment policy as stated above.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Please review the following patient consent form:**

**your application will not be processed until you complete and sign**

**PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- obtaining payment from third party payers (Medicaid and/or CHP+)
- day-to-day healthcare operations of our practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: \_\_\_\_\_

Your Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Today's date: \_\_\_\_\_ Your Signature: \_\_\_\_\_