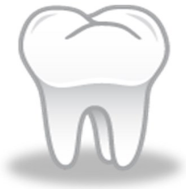

CGS

Building Leadership in Aging

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Senior Low Income Dental Program

INSTRUCTIONS TO APPLY FOR A SENIOR ANSWERS AND SERVICES DENTAL GRANT
PLEASE READ BEFORE FILLING OUT THE ENCLOSED FORM
Call 303-333-3482 or 1-855-293-6911 or 1-855-880-4777 (Spanish) if you have questions.
Download application at https://www.senioranswers.org/programs/dental-grants/
FAX COMPLETED FORM TO 303-333-9112

Older adults age 60 and over who live in Adams, Arapahoe, Broomfield, Clear Creek, Delta, Denver, Douglas, Eagle, Garfield, Gilpin, Jefferson, La Plata, Mesa, Montrose, or Summit. county may apply for a grant for partial assistance with dental care (including covers exams, x-rays, extractions, fillings, full and partial dentures, relines and cleanings. The program will not cover crowns, root canals, fixed bridges, and implants. Priority is given to older adults who are in the greatest economic and social need.

HOW TO APPLY FOR A GRANT:

1. Complete the attached Application.
2. Select a dentist. You may select a dentist from the list or you may use your own dentist, but your dentist must be willing to accept the grant as payment in full.
3. Contact the dentist and ask if they will accept you as a patient on the Senior Answers and Services Dental Program.
4. Submit the completed Application to Senior Answers and Services, Dental Program, 1129 Pennsylvania St, Denver CO 80203 (Be sure to sign the Application Form and the HIPPA - Disclosure Form) INCOMPLETE FORMS WILL BE RETURNED.
5. You will be placed on the waiting list.

WHEN YOU ARE SELECTED TO RECEIVE A GRANT:

1. When funding is available, you will receive an Initial Grant Award Letter to make an appoint for an exam.
2. After your exam, a treatment plan will be submitted by your dentist for a grant to cover the necessary dental services.
3. When you receive the Final Grant Award Letter, make another appointment with the dentist to get your dental work completed. You will have 60 days to complete the work.
4. The dentist will request payment from Senior Answers.
5. ANY CHARGES OVER THE AMOUNT APPROVED ARE THE PATIENT'S RESPONSIBILITY.
6. The Low Income Senior Dental Program is not able to meet emergency needs.

THINGS TO KNOW:

1. The Senior Answers program is not insurance.
2. **ALL WORK THAT IS NOT COMPLETED BY JUNE 30, 2021 WILL NOT BE PAID BY THE GRANT.**
3. Grants are for a limited time. All work must be completed within 60 days.
4. There is no guarantee of a grant, as grants are dependent on funding availability.

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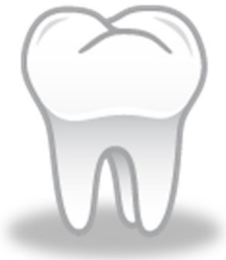


Senior Low Income Dental Program
Required Documentation

Please include ALL of the following documents:

1. Copy of your driver's license, Colorado ID, legal alien card and/or passport with current address
2. Copy of your letter from the Department of Human Services if you receive Medicaid
3. Copy of your health insurance card (front and back)
4. Copy of your dental insurance card, if applicable ((front and back)
5. Copy of your dental discount card, if applicable (front and back)

Failure to provide these documents will delay processing your application.

Please sign ALL of the following pages:

1. Sign the Application Form on Page 5
2. Sign the HIPPA Authorization Form on Page 6
3. Sign the Affidavit of Lawful Presence on Page 7

NOTE:

IF YOU ARE CURRENTLY RECEIVING MEDICAID OR HAVE DENTAL INSURANCE, WE WILL NOT BE ABLE TO ASSIST YOU THROUGH THE SENIOR LOW INCOME DENTAL PROGRAM. YOU MAY APPLY, BUT YOU WILL RECEIVE A DENIAL LETTER.

Return the Signed Application and Attachments To:

Colorado Gerontological Society
Senior Answers and Services Division
1129 Pennsylvania St
Denver, Colorado 80203
303-333-3482 • 303-333-9112 (fax)
www.senioranswers.org
FAX APPLICATION TO 303-333-9112

This program is funded through the Colorado Department of Health Care Policy and Financing and private donations.

Senior Low Income Dental Program Application

Name: (Please Print)

First: _____ Middle: _____ Last: _____

Address: _____ Apt #: _____

City: _____ State: ____ Zip: _____ County: _____

Phone: (H) _____ (C) _____ Email _____

Date of Birth: _____ Social Security Number : _____

Gender: □ Male □ Female Marital Status: □ Single □ Married

Do you live in an Assisted Living? □ Yes □ No Do you live in a Nursing Home? □ Yes □ No

Alternate Contact:

Name: _____ Phone: _____ Relationship: _____

Health Insurance:

ATTACH A COPY OF YOUR MEDICARE CARD, INSURANCE CARD AND/OR DENTAL INSURANCE CARD

Do you currently have Medicare: □ Yes □ No If so, what is your Medicare number? _____

Do you currently have Medicaid: □ Yes □ No If so, what is your case number? _____

Do you currently have Health Insurance? □ Yes □ No

Name of Health Insurance Company _____

Policy Number: _____

Do you currently have Dental Insurance? □ Yes □ No

Name of Dental Health Insurance Company _____

Policy Number: _____ Group: _____

Are you a veteran? □ Yes □ No If so, do you receive healthcare through the VA? □ Yes □ No

Monthly GROSS INCOME from <u>ALL</u> sources is:

SINGLE

- □ Less than $1011
- □ Between $1012 and $1300
- □ Between $1301 and $1871
- □ Between $1872 and $2657
- □ More than $2658

MARRIED

- □ Less than $1371
- □ Between $1372 and $1700
- □ Between $1701and $2537
- □ Between $2538 and $3590
- □ More than $3591

Language Ability: [Check all that apply]

□ I have difficulty reading English, and require help to do so.

□ I have difficulty writing English.

□ I do NOT SPEAK enough English to talk to someone who only speaks English and have them understand.

□ I do NOT UNDERSTAND enough English to speak to an English speaking person without the aid of an interpreter.

□ My primary language is _____

Race and/or Ethnicity: [Please Check]

□ American Indian Alaska Native □ Black/African-American □ Hispanic/Latino □ Asian □White

□ Native Hawaiian/Other Pacific Islander □ Other (*please specify)* _____

Please list ALL sources of income and the monthly amount of income from each source:

□ Spouse's Income $ _____ □ Employment $ _____ □ Other not listed $ _____

□ Social Security $ _____ □ Social Security Disability $ _____ □ Supplemental Security Income $ _____

□ Old Age Pension $ _____ □ Private Pension $ _____ □ Veterans Pension $ _____

□ Dividends $ _____ □ Minerals/Royalties $ _____ □ Farm/Rental Income $ _____

□ Stocks/Bonds $ _____ □ Interest $ _____ □ Mutual Funds/Annuities $ _____

NET WORTH - List ALL additional resources and amounts:

□ Checking Account Balance(s) $ _____ □ Savings Account Balance(s) $ _____

□ Money Market(s) Balance(s) _____ □ IRA's Balance(s) $ _____ □ Roth IRA's Balance(s) $ _____

□ Mutual Fund/Annuities Balance(s) $ _____ □ Farm Income/Rental Income (Annual) $ _____

□ Stocks (Market Value) $ _____ □ Bonds (Market Value) $ _____ □ Oil and Gas Income (Annual) □ $ _____

Check ALL benefits you currently receive:

□ Supplemental Security Income (SSI)

□ Colorado Old Age Pension (OAP)

□ Supplemental Nutrition Assistance Program (SNAP/Food Stamps)

□ Low Income Energy Assistance Program (LEAP)

□ Rent Subsidy (Section 8 or HUD housing)

□ Colorado Property/Tax/Rent/Heat Rebate (PTC 104)

□ Temporary Assistance for Needy Families (TANF)

□ InnovAge (PACE Program)

□ Medicare

□ Medicaid

Medicare Savings Program (MSP)

- □ Qualified Medicare Benefit (QMB)
- □ Qualifying Individual 1 (QI-1)
- □ Special Low-Income Medicare Benefit (SLIM-B)

□ Home and Community Based Services (HCBS)

□ Veterans Administration Benefits (VA Benefits)

□ Tricare for Life/Military Benefits

□ A Health Maintenance Organization (HMO), Private Fee for Service (PFFS), Special Needs Plan (SNP) (please specify)

_____

Check ALL that apply:

ADLs (Activities of Daily Living)

□ I can eat without help

□ I can dress myself without help

□ I can bathe myself without help

□ I can use the toilet without help

□ I can get in and out of bed/chairs without help

□ I can get around inside my home without help

IADLs (Instrumental Activities of Daily Living)

□ I can manage money without help

□ I can take care of shopping without help

□ I can take my medication without help

□ I can prepare meals without help

□ I can do ordinary housework without help

□ I can use the telephone without help

□ I can use transportation without help

Are you currently receiving assistance with ADLs and or IADLs? □ Yes □ No *If Yes, from whom*:

Name _____ Phone _____

Relationship _____

Dental Needs

Check ALL that apply

□ I have difficulty chewing food
□ Because of my dental problems, I have had to change the types of food that I eat
□ My dental problems have caused me to gain or lose more than 10 pounds
□ I am unwilling or embarrassed to smile because of the state of my teeth
□ I have had ongoing problems with cavities, gum disease or another dental condition
□ If other, please name condition(s) below

_____

□ I have an ongoing non-dental health problem that is impacting my oral health **[please list condition(s) below]**

_____

Check ALL that apply

I may need dentures:

□ My dentures are lost/broken or I have recently had all or some of my teeth removed.
□ I have difficulty speaking because of my lack of teeth.
□ I cannot eat solid food
□ Even without smiling, I am ashamed to go out because of my appearance.

My existing denture(s) may need alteration:

□ My current denture no longer works for me (improper fit, lack of anchor)
□ My denture is causing sores in my mouth well after the adjustment period
□ I am having trouble swallowing because of the poor fit of my denture/ plate
□ I am having trouble speaking because of the poor fit of my denture/plate

I may have other dental needs:

□ I am frequently in noticeable pain
□ I have teeth that are outwardly decayed or broken
□ The pain in my mouth sometimes affects my ability to brush and floss my other teeth
□ I have had infections in my mouth due to the current condition of my teeth

CHOOSE A DENTIST

1. Choose a dentist from the attached list (or ask your personal dentist if he/she will accept a grant from our program)
2. Call the dentist to ask if they will take you as a patient with Senior Answers and Services dental program.

Dentists Name:_____

Clinic/Office name:_____

Address: _____ City/Zip: _____

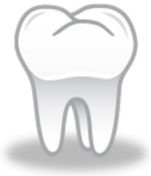
Phone: _____ Fax:_____

PLEASE SIGN

By signing and dating below, I certify that the above information on this application is true and to the best of my ability. Under penalty of perjury if I have falsified any of the above information, I understand that my grant will be terminated and that I will be responsible for paying any monies paid on my behalf to the Colorado Gerontological Society within 10 days in which the grant is terminated. I also understand that failure to pay may result in further legal action.

SIGNATURE _____ **DATE** _____/ _____/_____

EMERGENCY CONTACT _____ PHONE _____



HIPAA Authorization to Disclose Information to the Colorado Gerontological Society

I voluntarily authorize and request disclosure to the Colorado Gerontological Society, Senior Answers and Services Division of such medical information as may be needed to provide the necessary care for me including through written, spoken and electronic communication.

WHAT INFORMATION WILL BE DISCLOSED?

All records and other information regarding dental assessments, recommended treatments, dental work performed as well as not performed or declined, referrals to other dental providers, and complicating medical conditions or other impairments, as well as information about how my impairments affect my ability to complete the authorized treatment plan.

WHO MAY DISCLOSE INFORMATION ABOUT ME?

All dental and medical sources including but not limited to: dentists, oral surgeons, hospitals, clinics, labs, physicians, psychologists, mental health workers, correctional, addiction treatment, VA health care facilities, social workers, case managers, case workers, rehabilitation counselors, consulting dental providers, employers, and others who may know about my condition such as the person who helps me fill out this form, family, interpreters, friends, neighbors, and public officials.

TO WHOM MAY INFORMATION BE DISCLOSED?

To the Colorado Gerontological Society, Colorado Department of Health Care Policy and Financing, and other agencies or organizations that fund or finance this program, or which help to administer this dental program, program auditors, dental providers, and other medical professionals consulted.

THE PURPOSE OF THIS AUTHORIZATION IS

To determine the specific services for which this project will make a grant, to monitor the provision of services leading to successful completion of the authorized treatment plan, or terminate of treatments and the grant.

GENERAL PROVISIONS

This authorization is good for five years from the date signed (next to my signature below). I authorize the use of a photocopy, faxed copy, or other electronic copy of this form for the disclosure of the information described above. I may write to the Colorado Gerontological Society to revoke this authorization at any time. The Colorado Gerontological Society will give me a copy of this authorization if I request it by phone or in writing.

Complete and sign below if you agree to the above statements so we can share the information needed to serve you.

Name: _____Date of Birth _____/_____/_____

Address: _____ City/Zip: _____

Phone: (H) _____ (C) _____ Email _____

State Medicaid ID Number (if applicable): _____ Social Security Number _____

I have carefully read, understand and agree to the above disclosures.

SIGNATURE: _____ DATE: _____/_____/_____

COLORADO
Department of Health Care Policy & Financing

AFFIDAVIT FOR LAWFUL PRESENCE
COLORADO INDIGENT CARE PROGRAM

I,_____, swear of affirm under penalty of perjury under the laws of the State of Colorado that **(check one)**:

- ☐ I am a United States citizen.
- ☐ I am not a United States citizen but I am a Permanent Resident of the United States.
- ☐ I am not a United States citizen but I am lawfully present in the United States pursuant to Federal law.

I understand that this sworn statement is required by law because I have applied for a "state public benefit", as that term is defined under section 24-76.5-102(3), C.R.S. (2016). I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under section 18-8-503 C.R.S. (2016), and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature: Date:

FOR INTERNAL USE ONLY

Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document present in the applicant's file.

- ☐ A current, valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless that license or card states: "Not Valid for Federal Identification, Voting, or Public Benefit Purposes", or
- ☐ Any out-of-state driver's license or state-issued identification card if that state requires that the Applicant prove lawful presence prior to issuance of the license or identification card, or
- ☐ A United States military or a military dependent's identification card, or
- ☐ A United States Coast Guard Merchant Mariner card, or
- ☐ A Native American tribal document, or
- ☐ Other documentation pulled from SAVE or found on a Federal list of acceptable documentation for establishing lawful presence (see 1 CCR 204-30 §§ 2.1.4 and 2.1.6)
  Name of document accepted (include document number):_____
  Date verified in SAVE (if applicable):_____