Friends of Calvert County Seniors, Inc.
Dental Program for Seniors

The purpose of the Dental Program for Seniors is to ensure that the seniors with limited income and resources receive proper dental care. This program was established to provide complete dental care to eligible seniors residing in Calvert County. This program is a collaborative effort among the Friends of Calvert County Seniors, Inc., The Calvert County Office on Aging, and the Dental Community.

Applicants must be at least 60 years of age and a Calvert County resident. You must completely fill out the attached Application. Eligibility will be determined based on the current SLMB income and asset scale.) Income and asset levels must not exceed the following:

	Monthly Income	Assets
Individual	$1,379.00	$7,400.00
Couple	$1,851.00	$12,600.00

The income and assets of a spouse who lives with the applicant is counted in the calculation process. The senior will provide verification of the following information: Gross Income and assets.

Dental Program for Seniors - Friends of Calvert County Seniors, Inc.

Incomplete applications will not be considered (Please Print)

Name:	
Spouse's Name:	
Mailing Address:	
Phone Number:	
Date of Birth:	Race:
Last Four Digits of Your Social Security Number:	

Type of Income (Please Attach Proof)	Amount Per Month	Spouse's Amount
Social Security/SSI		
Veteran's Benefits		
Annuity/Pension		
Medical assistance	Yes______ No______	
Other		

Assets (Please Attach Proof)	Bank/Company	Value
Savings		
Checking		
Other		

Are you a veteran?
Dental Problems/Services Needed:

Doctor's Name:
Phone Number:

Dentist's Name:
Phone Number:

If accepted into this program, I agree to pay the Friends of Calvert County Seniors back 15% of the total amount paid in dental services on my behalf. Furthermore, I admit to the truthful information was provided on this application.

I agree to the statement above and understand that I will need to repay 15% of my total bill back to FCCS, Inc.

Signature:______________________Date:_________________

I would like this person to be contacted on my behalf regarding dental services:

Contact Person:
Phone Number:
Email Address:

Please return application to:

FCCS
P.O. Box 925
Prince Frederick, MD 20678

Office Use Only:

Date Received:
Signature:

Comments: