Return to:
KIDS IN NEED OF DENTISTRY
2465 SOUTH DOWNING ST SUITE 210
DENVER, CO 80210
TEL 303-733-3710 EXT 115
FAX 303-722-7710

Please PRINT and **fully** fill out this form or it will be returned

KIND

Kids in Need of Dentistry Application

_________Approved
_________Denied
_________Percent
_________MED/CHP+
_________INITIALS
DATE___________

Email:

Head of household		**Spouse or other:**	

Address:	**City:**	**State:**	**Zip Code:**

Home Phone:	**Cell Phone:**	**Work Phone:**

Total #of Family Members:	**Total # of people living at your house:**	**Total over the age 18:**

Is/Are your child(ren) currently a Kids In Need Of Dentistry (KIND) Patient ☐ Yes ☐ No

Do any the children currently have private insurance? ☐ Yes ☐ No If so please list name of insurance ______________________

Children Applying for Kids in Need of Dentistry Program

Childs Name (Under 18years of age Only)	**Sex**	**Birth Date**	**Please select one of the following and provide ID# if it applies**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**
	☐ M ☐ F		☐ CHP+ ☐Medicaid ☐ WIC ☐ No Insurance **ID#**

If your child has Medicaid, CHP+ or WIC you must send the following Documentation:

- Copy of Medicaid Card or CHP+ Card
- 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 FOR EVERY WORKING ADULT IN THE HOUSEHOLD,** by sending the documents required as follows:

- Copy of income tax return for the most current year.
- Copy of recent pay stubs for two consecutive months for each working adult in the household, or a 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 ADDITONAL INCOME** if you receive any of the following:

- Any additional income sources not listed above
- Child Support
- Social Security Benefits
- Disability Benefits

I certify that I have read and understand the above information to the best of my knowledge; the above questions have been answered accurately. I understand the providing false or incorrect information on this form or the supportive documents may cause dismissal of family members from the Kids in Need of Dentistry Program(s).

Name____

Signature____ Date__________________