Wyoming Department of Health

Commit to your health.

STATE OF WYOMING
SENIOR DENTAL HEALTH PROGRAM

ELIGIBILITY:

Low-income seniors, 65 years and older, can submit an application to the Oral Health Program. We require verification of income. An eligibility letter will be sent to the seniors meeting our acceptance guidelines.

There is no continued eligibility. An application must be filled out every year. Un-used benefits will not be carried over to the new calendar year from the previous calendar year.

BENEFITS:

This is a co-payment program. The State of Wyoming will pay 80 percent of the dental provider's fees and the patient will pay the remaining 20 percent of the dental provider's fees. The MAXIMUM BENEFIT IS $800 in any calendar year when funds are available. If the patient has reached his or her maximum benefit amount, and still requires treatment, the patient will be responsible for any balance over their benefit amount.

For questions, or assistance with applying for the Senior Dental Health Program, please contact the Oral Health Section at:

By Phone: (307) 777-7945
By Fax: (307) 777-8687
In Writing:
Wyoming Department of Health
Oral Health Program
6101 Yellowstone Road, Suite 420
Cheyenne, WY 82002

WE REQUIRE VERIFICATION OF INCOME.
COPY OF LAST YEARS W-2 OR LAST PAY
STUB OR SOCIAL SECURITY AND/OR
RETIREMENT STATEMENT.

CONFIDENTIAL
APPLICATION FOR SENIOR DENTAL HEALTH PROGRAM

PATIENT'S NAME:_____
FIRST MI LAST

BIRTH DATE:_____
MONTH DAY YEAR

ADDRESS:_____
STREET APT./LOT #

_____
CITY STATE ZIPCODE

PHONE #:
HOME_____**WORK**_____**CELL**_____

SINGLE_____ **MARRIED**_____ **WIDOW**_____ **WIDOWER**_____
(Please Check Appropriate Status)

MEDICAID: YES_____ **NO**_____ **IF YES, MEDICAID NUMBER**_____

LIST YOUR MONTHLY INCOME_____

SPOUSE'S INCOME, IF MARRIED_____

SOURCES OF INCOME_____

LAST YEAR'S TOTAL INCOME_____

LIST YOUR MONTHLY PRESCRIPTION COST AND MEDICAL BILLS_____

_____

NAME OF YOUR BANK_____

AMOUNT ON DEPOSIT_____

NAME OF YOUR DENTIST_____

ALL INFORMATION I HAVE GIVEN ON THIS CONFIDENTIAL FINANCIAL STATEMENT AND APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____**DATE**_____

RETURN TO:
DEPARTMENT OF HEALTH
ORAL HEALTH PROGRAM
6101 YELLOWSTONE ROAD, SUITE 420
CHEYENNE, WY 82002