APPLICATION FOR THE SEVERE CRIPPLING MALOCCLUSION PROGRAM

Return Application AND REFERRAL to: 6101 Yellowstone Road, Suite 420, Cheyenne, WY 82002

1. Patient Information:						
Name:			Iale/Female Birth date:			
Last Name, First Name,	MI					
Mailing Address:						
Street Address or P.	O. Box	City	County	Zip Code		
Physical Address:						
(If not the same as mailing address) Stre	et Address	City	County	Zip Code		
Social Security Number:	Medicaid/Equality Care Number:					
(Optional)						
Home Phone:	Work Phone:		Message Phone:			
2. Parent/Guardian Information:						
Name of Father / (Step) / Guardian:						
Name of Mother / (Step) / Guardian:						
Address if different from Patient:						
Total Number of People Living In Household:(Complete Family Case Sheet, page 3)						
3. <u>Dentist/Orthodontist/PHN:</u>						
Name and Address of Dentist:						
Name and Address of Dentist.						
Name and Address of Orthodontist:						
Name and County of PHN (Public He	alth Nurse) or School Nu	rse:				
<u>,</u>	•					

The information you have provided will remain confidential with the Department of Health, **EXCEPT** in the following circumstances:

The Dental Health Program (DHP) as part of the Department of Health is a covered entity. DHP may request from any state agency, insurer, group health plan, health maintenance organization or similar entity any or all of your protected health information. This information includes the recipient's name, social security number, amount of payment, charge for services, date of services, and services rendered related to medical payment. This information may be used or disclosed for the process of treatment, payment or healthcare operations. This is in accordance with the Health Information Portability and Accountability Act section 164.502(a)(1)(ii). Please see your Client Privacy Rights Policy for use and disclosure of your protected health information.

Please send in all 3 pages together with a referral from your child's regular dentist.

CONFIDENTIAL FINANCIAL INFORMATION

APPLICATION WILL BE CONSIDERED INCOMPLETE WITHOUT RECENT PAY STUBS \underline{AND} LAST YEAR'S INCOME TAX RETURN

(EqualityCare Recipients (Title 19) only need to fill out Dental Insurance Portion on this page and do not need to submit pay stubs and income tax return)

4. PERSONAL INCOME (INCLUDE ALL INCOME FROM ALL MEMBERS IN THE HOUSEHOLD)

(HOUSEHOLD MEMBERS INCLUDE - Parent (s), stepparents, legal guardian, parent's significant other, grandparent, sibling, aunt/uncle, etc.)

erage inform	ation) If the	re is no Dental Insuranc	ee indicate "None"
		Benefits	
	erage inform	erage information) If the	erage information) If there is no Dental Insurance Benefits

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5.

FAMILY CASE SHEET

This social summary will be used to assist in determining eligibility for Dental Services provided by the Dental Health Program. All information given is kept confidential.

Patient's Name:		DOB:			
Address:					
City, State, Zip:					
ALL MEMBERS IN H	OUSEHOLD - NOT INCI	LUDING PATIENT			
Name: Last, First	Relationship to Patient	Birthdate (mm/dd/yy)	Occupation/School		
I (We) apply for orthodontic care of					
The information you have provided will remain co	onfidential with the Department	of Health, EXCEPT in the	following circumstances:		
The Dental Health Program (DHP) as part of the insurer, group health plan, health maintenance of information includes the recipient's name, social services rendered related to medical payment. The healthcare operations. This is in accordance with Please see your Client Privacy Rights Policy for under the privacy Rights Policy Rights Policy for under the privacy Rights Policy Rights	organization or similar entity and security number, amount of this information may be used the Health Information Portab	any or all of your protected f payment, charge for servi- or disclosed for the process positive and Accountability Acc	health information. This ces, date of services, and of treatment, payment o		
I hereby authorize the release of information lindental plans, third party administrators, health main					
ALL INFORMATION I HAVE PROVI	DED ON THIS APPLICAT MY KNOWLEDGE.	ΓΙΟΝ (3 pages) IS TRUI	E TO THE BEST OF		
Signature:		Date:			

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