Return to: Ms. Gayle Gilbaugh
Center for Disabilities and Development
100 Hawkins Drive
Iowa City, IA 52242-1011
(319) 356-1513

DENTAL CARE FOR PERSONS WITH DISABILITIES
INCOME DECLARATION & CONSENT FORM

I have been informed, understand and consent to receive the dental services offered to my child:______________________________________ Birth Date _________________ through the "Dental Care for Persons with Disabilities Program". I understand my responsibilities as a client and agree to assume these responsibilities in this program.

I understand that the Project Director, Project Coordinator or their designee of the Iowa Department of Public Health shall have access to all information available from records maintained by this agency.

I understand that a voluntary declaration of income and numbers of persons in my family are necessary to assure that Federal and State funds are directed to those persons least able to secure services from other sources.

My family's **monthly** gross income is $_________________ Number in my family is:_______________
Does the applicant receive Medicaid (Title XIX) or SSI? Yes _____ No _____
Does the applicant have dental insurance? Yes_____ No _____
Does the applicant participate in the Headstart Program? Yes _____ No _____
How many months in the past 12 has the primary wage earner of the family been employed? ______
Has your family experienced any hardships such as high medical expenses, disaster or loss of employment in the past 12 months that have seriously depleted your income? Yes _____ No _____
If yes, explain on the reverse side of this form.

My child has the following disability or handicapping condition (s):___________________________
____

The last dentist my child saw was: Name________________________City________________________

Date of treatment: _____________________ Treatment done __________________________________

____ ____
Parent/Guardian name (Please type or print) **Signature of parent (guardian or applicant)**

Address____

City_____________________State_________ Zip code________

Phone________________________ County________________

Who referred you to this program?

____
Name Position/Agency

____
Address City State Zip code

____
For Office Use
TQ ____ D ____ Renewal _____

Ames ____	Pella ____
Bellevue____	Monticello ____
Carroll _____	Mason City___
C Bluffs ____	Monona ____
Creston____	Sioux Center ____
Iowa City ____	Sioux City ____
Laurens ____	Waukon ____
Maquoketa ___	Marshalltown ___
Story City___	W. Burlington ___
Des Moines ___	

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