



DENTAL CLINIC

834 N. Columbia Street, Covington, LA 70433
985-871-3939

Dear Applicant,

Please read the following carefully. Any applications missing information and/or documentation **will not be processed**.

The CFB Dental Clinic is a non-profit, **low fee** program that serves our local, low income community with their dental needs.

In order to maintain a low fee, we do not bill or offer a payment plan. We do not accept any form of insurance or Medicaid. Payment is due when the work is performed.

Documentation Required:

- Applicants must be gainfully employed, retired or disabled and provide a copy of 2 most recent pay stubs or a copy of their current benefits. Hand written letters of employment must be on company stationary with contact phone numbers.
- Copy of a photo I.D. with a local address
- Copy of your social security card or a federal document with the number printed on it (such as your benefits letter, Medicaid card or tax return)
- Proof of residency for St. Tammany, Tangipahoa or Washington Parish in the form of: utility, cable or landline phone bill or lease with the applicant's name on the bill. We will NOT accept junk mail or car insurance bills.

LETTERS OF ACCEPTANCE- Applications are processed every 2 weeks. Exceptions may be made for emergency services. Letters of acceptance are mailed out with an acceptance date. You will have 60 days from your acceptance date to call and schedule your New Patient Exam. Your New Patient Exam fee is \$80.00. This is for a full set of X-rays, oral exam and treatment plan. If you do not show up for your New Patient exam, you will be dropped and can re-apply **ONE TIME** in 6 months.



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Your application **must** be complete and include **all documentation** to be processed.

COPIES PER APPLICANT:

- ___ PHOTO ID
- ___ SOCIAL SECURITY CARD or FEDERAL DOCUMENT W #
- ___ PROOF OF RESIDENCY
- ___ PROOF OF INCOME (and child support)

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH _____

DRIVERS LICENSE/ID # _____

EMPLOYER _____ WORK PHONE # _____

OF WORKING HRS PER WEEK _____ WAGES PER HOUR _____

AND/OR

RETIREMENT/DISABILTY BENEFITS PER MONTH _____

DO YOU PAY/RECEIVE CHILD SUPPORT (circle if applicable)? AMOUNT PER MONTH _____

MARITAL STATUS (circle one) SINGLE MARRIED WIDOWED DIVORCED

PLEASE INCLUDE MY SPOUSE AS AN APPLICANT:

SPOUSE NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ - _____ - _____ CELL PHONE _____

DRIVERS LICENSE/ID # _____

EMPLOYER _____ WORK PHONE _____

SPOUSE WORKING HRS _____ SPOUSE WAGES/SALARY _____

AND/OR

RETIREMENT/DISABILTY BENEFITS PER MONTH _____

CURRENT HOUSING (circle one) RENT HOME W/MORTGAGE HOME /PAID-OFF

PLEASE LIST ALL PEOPLE LIVING IN YOUR HOUSEHOLD. INCLUDE YOURSELF AND LIST CHILDREN LAST.

| NAME | DOB | WEEKLY WORK HRS | RATE/SALARY |
|------|-----|-----------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |

DO YOU OR ANY OTHER MEMBER ATTEND COLLEGE? YES / NO (circle one) IF YES,
 # OF HOURS PER WEEK _____ YEARLY TUITION _____
 NAME OF STUDENT _____ SCHOOL _____

DO YOU OR ANYONE IN YOUR FAMILY HAVE DENTAL INSURANCE? YES NO

LIVING EXPENSES/MONTHLY (if left blank, you will be denied) _____

RENT/MORTGAGE _____ TOTAL UTILITIES _____

PHONE BILL _____ MEDICAL _____

CHILD CARE _____ GROCERIES _____

CABLE _____ CAR INSURANCE _____

CREDIT CARDS _____ HOME INSURANCE _____

CAR PAYMENT _____

CURRENT DENTAL NEEDS

Administration only

Received date _____ LOA _____ LOD _____

NPEX _____ SCH A _____ SCH B _____

TFI _____ HH# _____