Smile New Jersey/Mobile Dentists...*In-School Dental Prevention Program*

Dear Parents or Guardian,

If you need financial assistance so your child can receive a dental exam, please check the appropriate box and fill out the required information.

School: _____

Child's Full Name: _____ Date of Birth: _____ Phone #: _____

Parent/Guardian Name: _____ e-mail: _____

Address: _____

Please check areas that apply to you and fill out the information:

☐ **My child has Medicaid/NJ Family Care The 12-digit ID number is:**___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ **I don't have Medicaid and wish to apply to <u>NJ Family Care.</u>**

NJ Family Care is an affordable insurance program, offered by the State of New Jersey for children birth through age 18. To qualify for this, a child must be a New Jersey resident, under age 19, and live in a family that makes at or below the income in the chart below.

	Poverty level (Annual Incomes)					
Family Size	0-133%	133%-150%	150%-200%	200%-250%	250%-300%	300%-350%
1 child	$13,832	$15,600	$20,800	$26,000	$31,200	$36,400
2 people	$18,620	$21,000	$28,000	$35,000	$42,000	$49,000
3 people	$23,408	$26,400	$35,200	$44,000	$52,800	$61,600
4 people	$28,196	$31,800	$42,400	$53,000	$63,600	$74,200
5 people	$32,984	$37,200	$49,600	$62,000	$74,400	$86,800
6 people	$37,772	$42,600	$56,800	$71,000	$85,200	$99,400
7 people	$42,560	$48,000	$64,000	$80,000	$96,000	$112,000

To apply for NJ Family Care, call toll-free 1-800-701-0710 and complete the following information:

Child's social security #: _____

HEAD OF HOUSEHOLD social security #: _____

Name of person I spoke to at NJ Family Care: _____ Date: _____

☐ **I have no dental insurance and do not wish to apply to NJ Family Care**. I need to pay for a subsidized service because I am unable to pay full fee. It will cover dental cleaning, screening & fluoride.

Ages 15 or younger: $78.00 Ages 16 or older: $98.00

Please make check or money order payable to **Smile New Jersey, PLLC** and staple to this form.

☐ **I have other dental insurance.** *(Please attach a copy of the front and back of the insurance card to this form and complete the information below).*

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Social Sec. #: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Contract #: _____

Insurance Company: _____ Group Number: _____

Insurance Company Phone #: _____

Employer Name: _____ Employer Phone #: _____

☐ **I request financial assistance to cover the cost of a dental exam for my child.** I certify that my monthly household income is at or below the monthly income limits above, and I am not eligible for Medicaid, CHIP or any other dental assistance programs.

✘ Sign Here _____ Date _____

Parent/Guardian

We look forward to seeing your child. Please return to school as soon as possible.

Thank you,

Smile New Jersey/Mobile Dentists

www.mobiledentists.com