Older adults age 60 and over who live in Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Gilpin, or Jefferson county may apply for a grant for partial assistance with dental care (including covers exams, x-rays, extractions, fillings, full and partial dentures, relines and cleanings. The program will not cover crowns, root canals, fixed bridges, and implants. Priority is given to older adults who are in the greatest economic and social need.

HOW TO APPLY FOR A GRANT:

1. Complete the attached Application.
2. Select a dentist. You may select a dentist from the list or you may use your own dentist, but your dentist must be willing to accept the grant as payment in full.
3. Contact the dentist and ask if they will accept you as a patient on the Senior Answers and Services Dental Program.
4. Submit the completed Application to Senior Answers and Services, Dental Program, 3006 East Colfax Avenue, Denver CO 80206 (Be sure to sign the Application Form and the HIPPA - Disclosure Form)

   INCOMPLETE FORMS WILL BE RETURNED.
5. You will be placed on the waiting list.

WHEN YOU ARE SELECTED TO RECEIVE A GRANT:

1. When funding is available, you will receive an Initial Grant Award Letter to make an appoint for an exam.
2. After your exam, a treatment plan will be submitted by your dentist for a grant to cover the necessary dental services.
3. When you receive the Final Grant Award Letter, make another appointment with the dentist to get your dental work completed. You will have 60 days to complete the work.
4. The dentist will request payment from Senior Answers.
5. ANY CHARGES OVER THE AMOUNT APPROVED ARE THE PATIENT’S RESPONSIBILITY.
6. The Low Income Senior Dental Program is not able to meet emergency needs.

THINGS TO KNOW:

1. The Senior Answers program is not insurance.
2. ALL WORK THAT IS NOT COMPLETED BY JUNE 30, 2016 WILL NOT BE PAID BY THE GRANT.
3. Grants are for a limited time. All work must be completed within 60 days.
4. There is no guarantee of a grant, as grants are dependent on funding availability.

APPEAL RIGHTS:

You will receive a letter indicating that your Application has been received and that you have been placed on the waiting list within six weeks. You may appeal your place on the waiting list if you believe we have inaccurate or incomplete information on the Form. For a complete copy of the appeal procedures, please call 303-333-3482.
Senior Low Income Dental Program

Required Documentation

Please include ALL of the following documents:

1. Copy of your driver’s license, Colorado ID, legal alien card and/or passport with current address
2. Copy of your letter from the Department of Human Services if you receive Medicaid
3. Copy of your health insurance card (front and back)
4. Copy of your dental insurance card, if applicable (front and back)
5. Copy of your dental discount card, if applicable (front and back)

Failure to provide these documents will delay processing your application.

NOTE:
IF YOU ARE CURRENTLY RECEIVING MEDICAID OR HAVE DENTAL INSURANCE, WE WILL NOT BE ABLE TO ASSIST YOU THROUGH THE SENIOR LOW INCOME DENTAL PROGRAM. YOU MAY APPLY, BUT YOU WILL RECEIVE A DENIAL LETTER.

Please sign ALL of the following pages:

1. Sign the Application Form on Page 5
2. Sign the HIPPA Authorization Form on Page 6
3. Sign the Affidavit of Lawful Presence on Page 7

Your application will be processed more timely if all of these pages have been signed and dated.

Return the Signed Application and Attachments To:

Colorado Gerontological Society
Senior Answers and Services Division
3006 East Colfax Avenue
Denver, Colorado 80206
303-333-3482 • 303-333-9112 (fax)
www.senioranswers.org

This program is funded through the Colorado Department of Health Care Policy and Financing and private donations.
# Senior Low Income Dental Program Application

**Name:** (Please Print)

First: _________________________________ Middle: __________________ Last: __________________________

Address: _________________________________________________________________________  Apt #: _______

City: ______________________________ State: ____  Zip: ___________  County: ___________________________

Phone: (H) _____________________  (C)  ____________________  Email _______________________________

**Date of Birth:** __________________  **Social Security Number:** _______________________________________

**Gender:** □ Male  □ Female  
**Marital Status:** □ Single  □ Married

**Do you live in an Assisted Living?** □ Yes  □ No  
**Do you live in a Nursing Home?** □ Yes  □ No

**Alternate Contact:**

Name: ____________________________________  Phone: _______________________  Relationship: ____________

---

## Health Insurance:

**Do you currently have Medicare?** □ Yes  □ No  
If so, what is your Medicare number? _____________________________

**Do you currently have Medicaid?** □ Yes  □ No  
If so, what is your case number? _____________________________

**Do you currently have Health Insurance?** □ Yes  □ No

Name of Health Insurance Company _____________________________________________________________

Policy Number: ___________________________________________  Group: _____________________________

**Do you currently have Dental Insurance?** □ Yes  □ No

Name of Dental Health Insurance Company _______________________________________________________

Policy Number: ___________________________________________  Group: ______________________________

**Are you a veteran?** □ Yes  □ No  
If so, do you receive healthcare through the VA? □ Yes  □ No

---

## Monthly GROSS INCOME from ALL sources is:

<table>
<thead>
<tr>
<th>SINGLE</th>
<th>MARRIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Less than $793</td>
<td>□ Less than $1100</td>
</tr>
<tr>
<td>□ Between $794 and $1337</td>
<td>□ Between $1101 and $1803</td>
</tr>
<tr>
<td>□ Between $1337 and $2475</td>
<td>□ Between $1843 and $3338</td>
</tr>
<tr>
<td>□ More than $2475</td>
<td>□ More than $3338</td>
</tr>
</tbody>
</table>

---

**Language Ability:** [Check all that apply]

□ I have difficulty reading English, and require help to do so.

□ I have difficulty writing English.

□ I do NOT SPEAK enough English to talk to someone who only speaks English and have them understand.

□ I do NOT UNDERSTAND enough English to speak to an English speaking person without the aid of an interpreter.

□ My primary language is __________________________________________________________________________

---

**Race and/or Ethnicity:** [Please Check]

□ American Indian Alaska Native  □ Black/African-American  □ Hispanic/Latino  □ Asian  □ White

□ Native Hawaiian/Other Pacific Islander  □ Other  (please specify) ________________________________
Please list ALL sources of income and the monthly amount of income from each source:

- □ Social Security $ ____________ □ Social Security Disability $ ____________ □ Supplemental Security Income $ ____________
- □ Old Age Pension $ ____________ □ Private Pension $ ____________ □ Veterans Pension $ ____________
- □ Dividends $ ____________ □ Minerals/Royalties $ ____________ □ Farm/Rental Income $ ____________
- □ Stocks/Bonds $ ____________ □ Interest $ ____________ □ Mutual Funds/Annuities $ ____________

NET WORTH - List ALL additional resources and amounts:

- □ Checking Account Balance(s) $ ____________ □ Savings Account Balance(s) $ ____________
- □ Money Market(s) Balance(s) ____________ □ IRA’s Balance(s) $ ____________ □ Roth IRA’s Balance(s) $ ____________
- □ Mutual Fund/Annuities Balance(s) $ ____________ □ Farm Income/Rental Income (Annual) $ ____________
- □ Stocks (Market Value) $ ____________ □ Bonds (Market Value) $ ____________ □ Oil and Gas Income (Annual) $ ____________

Please check ALL benefits you currently receive:

- □ Supplemental Security Income (SSI)
- □ Colorado Old Age Pension (OAP)
- □ Supplemental Nutrition Assistance Program (SNAP/Food Stamps)
- □ Low Income Energy Assistance Program (LEAP)
- □ Rent Subsidy (Section 8 or HUD housing)
- □ Colorado Property/Tax/Rent/Heat Rebate (PTC 104)
- □ Temporary Assistance for Needy Families (TANF)
- □ InnovAge (PACE Program)
- □ Medicare
- □ Medicaid
- □ Medicare Savings Program (MSP)
  - □ Qualified Medicare Benefit (QMB)
  - □ Qualifying Individual 1 (QI-1)
  - □ Special Low-Income Medicare Benefit (SLIM-B)
- □ Home and Community Based Services (HCBS)
- □ Veterans Administration Benefits (VA Benefits)
- □ Tricare for Life/Military Benefits
- □ A Health Maintenance Organization (HMO), Private Fee for Service (PFFS), Special Needs Plan (SNP) (please specify)

[Check ALL that apply]:

ADLS (Activities of Daily Living)
- □ I can eat without help
- □ I can dress myself without help
- □ I can bathe myself without help
- □ I can use the toilet without help
- □ I can get in and out of bed/chairs without help
- □ I can get around inside my home without help

IADLs (Instrumental Activities of Daily Living)
- □ I can manage money without help
- □ I can take care of shopping without help
- □ I can take my medication without help
- □ I can prepare meals without help
- □ I can do ordinary housework without help
- □ I can use the telephone without help
- □ I can use transportation without help

Are you currently receiving assistance with ADLs and or IADLs? □ Yes □ No

If Yes, from whom:
Name __________________________________________ Phone __________________________________________
Relationship __________________________________________
# Dental Needs

[Check ALL that apply]:

- I have difficulty chewing food
- Because of my dental problems, I have had to change the types of food that I eat
- My dental problems have caused me to gain or lose more than 10 pounds
- I am unwilling or embarrassed to smile because of the state of my teeth
- I have had ongoing problems with cavities, gum disease or another dental condition
- If other, please name condition(s) below

___________________________________________________________________________________________________

- I have an ongoing non-dental health problem that is impacting my oral health [please list condition(s) below]

___________________________________________________________________________________________________

[Check ALL that apply]:

**I may need dentures:**

- My dentures are lost/broken or I have recently had all or some of my teeth removed.
- I have difficulty speaking because of my lack of teeth.
- I cannot eat solid food
- Even without smiling, I am ashamed to go out because of my appearance.

**My existing denture(s) may need alteration:**

- My current denture no longer works for me (improper fit, lack of anchor)
- My denture is causing sores in my mouth well after the adjustment period
- I am having trouble swallowing because of the poor fit of my denture/plate
- I am having trouble speaking because of the poor fit of my denture/plate

**I may have other dental needs:**

- I am frequently in noticeable pain
- I have teeth that are outwardly decayed or broken
- The pain in my mouth sometimes affects my ability to brush and floss my other teeth
- I have had infections in my mouth due to the current condition of my teeth

**Choose a Dentist**

1. Choose a dentist from the attached list (or ask your personal dentist if he/she will accept a grant from our program)
2. Call the dentist to ask if they will take you as a patient with Senior Answers and Services dental program.

Dentists Name:________________________________________________________________________________________

Clinic/Office name:____________________________________________________________________________________

Address: _________________________________________________ City/Zip: _________________________________

Phone: _____________________________________________ Fax:_______________________________________

By signing and dating below, I certify that the above information on this application is true and to the best of my ability. Under penalty of perjury if I have falsified any of the above information, I understand that my grant will be terminated and that I will be responsible for paying any monies paid on my behalf to the Colorado Gerontological Society within 10 days in which the grant is terminated. I also understand that failure to pay may result in further legal action.

SIGNATURE __________________________ DATE _______/ _______/_________  
EMERGENCY CONTACT __________________________ PHONE __________________________
HIPPA Authorization to Disclose Information to the Colorado Gerontological Society

I voluntarily authorize and request disclosure to the Colorado Gerontological Society, Senior Answers and Services Division of such medical information as may be needed to provide the necessary care for me including through written, spoken and electronic communication.

WHAT INFORMATION WILL BE DISCLOSED?

All records and other information regarding dental assessments, recommended treatments, dental work performed as well as not performed or declined, referrals to other dental providers, and complicating medical conditions or other impairments, as well as information about how my impairments affect my ability to complete the authorized treatment plan.

WHO MAY DISCLOSE INFORMATION ABOUT ME?

All dental and medical sources including but not limited to: dentists, oral surgeons, hospitals, clinics, labs, physicians, psychologists, mental health workers, correctional, addiction treatment, VA health care facilities, social workers, case managers, case workers, rehabilitation counselors, consulting dental providers, employers, and others who may know about my condition such as the person who helps me fill out this form, family, interpreters, friends, neighbors, and public officials.

TO WHOM MAY INFORMATION BE DISCLOSED?

To the Colorado Gerontological Society, Colorado Department of Health Care Policy and Financing, and other agencies or organizations that fund or finance this program, or which help to administer this dental program, program auditors, dental providers, and other medical professionals consulted.

THE PURPOSE OF THIS AUTHORIZATION IS

To determine the specific services for which this project will make a grant, to monitor the provision of services leading to successful completion of the authorized treatment plan, or terminate of treatments and the grant.

GENERAL PROVISIONS

This authorization is good for five years from the date signed (next to my signature below). I authorize the use of a photocopy, faxed copy, or other electronic copy of this form for the disclosure of the information described above. I may write to the Colorado Gerontological Society to revoke this authorization at any time. The Colorado Gerontological Society will give me a copy of this authorization if I request it by phone or in writing.

Complete and sign below if you agree to the above statements so we can share the information needed to serve you.

Name: __________________________________________ Date of Birth __________/_________/________
Address: __________________________________________ City/Zip: ________________________________
Phone: (H) ____________________________ (C) __________________________ Email ______________________________
State Medicaid ID Number (if applicable): __________________________ Social Security Number _______________________

I have carefully read, understand and agree to the above disclosures.

SIGNATURE: __________________________________________ DATE: ______/_______/_______
<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Address</th>
<th>Clinic Name</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gregory</td>
<td>Schlagel, DDS (Thornton)</td>
<td>710 Eppinger Blvd</td>
<td>AAA Family Dental Center I</td>
<td>Thornton</td>
<td>CO</td>
<td>80229</td>
<td>(303) 289-3358</td>
</tr>
<tr>
<td>Gregory</td>
<td>Schlagel, DDS</td>
<td>3805 Newton St</td>
<td>AAA Family Dental Center II</td>
<td>Denver</td>
<td>CO</td>
<td>80211</td>
<td>(303) 455-0233</td>
</tr>
<tr>
<td>Raquia</td>
<td>Denson, DDS</td>
<td>255 Union Blvd, Ste. 495</td>
<td>Alluring Smiles</td>
<td>Lakewood</td>
<td>CO</td>
<td>80228</td>
<td>(303) 989-1423</td>
</tr>
<tr>
<td>Eugene</td>
<td>Kang, DMD</td>
<td>1344 S Chambers Rd, Ste 201</td>
<td>Aurora Dental Group</td>
<td>Aurora</td>
<td>CO</td>
<td>80017</td>
<td>(303) 745-2052</td>
</tr>
<tr>
<td>Kathy</td>
<td>Tomlinson, DDS</td>
<td>1344 S Chambers Rd, Ste 201</td>
<td>Aurora Dental Group</td>
<td>Aurora</td>
<td>CO</td>
<td>80017</td>
<td>(303) 745-2052</td>
</tr>
<tr>
<td>Dwight</td>
<td>Bratton, DDS</td>
<td>1001 S Perry St, Ste. 104A</td>
<td>Castle Rock Dental Group P.C.</td>
<td>Castle Rock</td>
<td>CO</td>
<td>80104</td>
<td>(303) 663-6030</td>
</tr>
<tr>
<td>Chad</td>
<td>Carubia, DDS</td>
<td>1001 S Perry St, Ste. 104A</td>
<td>Castle Rock Dental Group P.C.</td>
<td>Castle Rock</td>
<td>CO</td>
<td>80104</td>
<td>(303) 663-6030</td>
</tr>
<tr>
<td>Michael</td>
<td>Miller, DDS</td>
<td>1001 S Perry St, Ste. 104A</td>
<td>Castle Rock Dental Group P.C.</td>
<td>Castle Rock</td>
<td>CO</td>
<td>80104</td>
<td>(303) 663-6030</td>
</tr>
<tr>
<td>Michael</td>
<td>Rowllette, DDS</td>
<td>1001 S Perry St, Ste. 104A</td>
<td>Castle Rock Dental Group P.C.</td>
<td>Castle Rock</td>
<td>CO</td>
<td>80104</td>
<td>(303) 663-6030</td>
</tr>
<tr>
<td>Jana</td>
<td>Rausa, DDS</td>
<td>2161 S Chambers Rd</td>
<td>Chambers Court Dentistry</td>
<td>Aurora</td>
<td>CO</td>
<td>80014</td>
<td>(303) 369-7735</td>
</tr>
<tr>
<td>Constanza</td>
<td>Cubillos, DDS</td>
<td>7990 N Sheridan Blvd</td>
<td>Comfort Dental 80th &amp; Sheridan</td>
<td>Westminster</td>
<td>CO</td>
<td>80003</td>
<td>(303) 650-4101</td>
</tr>
<tr>
<td>Ian</td>
<td>Ferguson, DMD</td>
<td>7990 N Sheridan Blvd</td>
<td>Comfort Dental 80th &amp; Sheridan</td>
<td>Westminster</td>
<td>CO</td>
<td>80003</td>
<td>(303) 650-4101</td>
</tr>
<tr>
<td>Ryan</td>
<td>Mangrum, DMD</td>
<td>7990 N Sheridan Blvd</td>
<td>Comfort Dental 80th &amp; Sheridan</td>
<td>Westminster</td>
<td>CO</td>
<td>80003</td>
<td>(303) 650-4101</td>
</tr>
<tr>
<td>Jason</td>
<td>Heintz, DDS</td>
<td>11625 W Bellevue Ave</td>
<td>Comfort Dental Bellevue &amp; Simms</td>
<td>Littleton</td>
<td>CO</td>
<td>80127</td>
<td>(303) 972-8700</td>
</tr>
<tr>
<td>Katrina</td>
<td>Rojohn, DDS</td>
<td>11625 W Bellevue Ave</td>
<td>Comfort Dental Bellevue &amp; Simms</td>
<td>Littleton</td>
<td>CO</td>
<td>80127</td>
<td>(303) 972-8700</td>
</tr>
<tr>
<td>Tam</td>
<td>Than, DDS</td>
<td>11625 W Bellevue Ave</td>
<td>Comfort Dental Bellevue &amp; Simms</td>
<td>Littleton</td>
<td>CO</td>
<td>80127</td>
<td>(303) 972-8700</td>
</tr>
<tr>
<td>Dan</td>
<td>Anderson, DDS</td>
<td>315 E Bromley Ln</td>
<td>Comfort Dental Brighton</td>
<td>Brighton</td>
<td>CO</td>
<td>80601</td>
<td>(303) 659-1125</td>
</tr>
<tr>
<td>John</td>
<td>Batters, DDS</td>
<td>315 E Bromley Ln</td>
<td>Comfort Dental Brighton</td>
<td>Brighton</td>
<td>CO</td>
<td>80601</td>
<td>(303) 659-1125</td>
</tr>
<tr>
<td>Dustin</td>
<td>Craven, DDS</td>
<td>315 E Bromley Ln</td>
<td>Comfort Dental Brighton</td>
<td>Brighton</td>
<td>CO</td>
<td>80601</td>
<td>(303) 659-1125</td>
</tr>
<tr>
<td>Mark</td>
<td>Jostad, DDS</td>
<td>201 University #101</td>
<td>Comfort Dental Cherry Creek</td>
<td>Denver</td>
<td>CO</td>
<td>80206</td>
<td>(303) 321-2233</td>
</tr>
<tr>
<td>Todd</td>
<td>Light, DDS</td>
<td>201 University #101</td>
<td>Comfort Dental Cherry Creek</td>
<td>Denver</td>
<td>CO</td>
<td>80206</td>
<td>(303) 321-2233</td>
</tr>
<tr>
<td>Braden</td>
<td>Robbins, DDS</td>
<td>201 University #101</td>
<td>Comfort Dental Cherry Creek</td>
<td>Denver</td>
<td>CO</td>
<td>80206</td>
<td>(303) 321-2233</td>
</tr>
<tr>
<td>Owen</td>
<td>Eames, DDS</td>
<td>7201 Monaco St</td>
<td>Comfort Dental Commerce City</td>
<td>Commerce City</td>
<td>CO</td>
<td>80022</td>
<td>(303) 287-2755</td>
</tr>
<tr>
<td>Rachel</td>
<td>O'Connor, DDS</td>
<td>7201 Monaco St</td>
<td>Comfort Dental Commerce City</td>
<td>Commerce City</td>
<td>CO</td>
<td>80022</td>
<td>(303) 287-2755</td>
</tr>
<tr>
<td>H Ramsey</td>
<td>Warner, DDS</td>
<td>7201 Monaco St</td>
<td>Comfort Dental Commerce City</td>
<td>Commerce City</td>
<td>CO</td>
<td>80022</td>
<td>(303) 287-2755</td>
</tr>
<tr>
<td>Richard</td>
<td>Doerhoff, DDS</td>
<td>2131 S. Chambers Rd.</td>
<td>Comfort Dental East Aurora</td>
<td>Aurora</td>
<td>CO</td>
<td>80014</td>
<td>(303) 750-2273</td>
</tr>
<tr>
<td>Richard</td>
<td>Heideman, DDS</td>
<td>2131 S. Chambers Rd.</td>
<td>Comfort Dental East Aurora</td>
<td>Aurora</td>
<td>CO</td>
<td>80014</td>
<td>(303) 750-2273</td>
</tr>
<tr>
<td>Sofie</td>
<td>Magaril, DDS</td>
<td>2131 S. Chambers Rd.</td>
<td>Comfort Dental East Aurora</td>
<td>Aurora</td>
<td>CO</td>
<td>80014</td>
<td>(303) 750-2273</td>
</tr>
<tr>
<td>Matt</td>
<td>Tobkin, DDS</td>
<td>2131 S. Chambers Rd.</td>
<td>Comfort Dental East Aurora</td>
<td>Aurora</td>
<td>CO</td>
<td>80014</td>
<td>(303) 750-2273</td>
</tr>
<tr>
<td>Jeff</td>
<td>Varner, DDS</td>
<td>2131 S. Chambers Rd.</td>
<td>Comfort Dental East Aurora</td>
<td>Aurora</td>
<td>CO</td>
<td>80014</td>
<td>(303) 750-2273</td>
</tr>
<tr>
<td>Heath</td>
<td>Collode, DMD</td>
<td>17531 S Golden Rd</td>
<td>Comfort Dental Golden</td>
<td>Golden</td>
<td>CO</td>
<td>80401</td>
<td>(303) 278-6953</td>
</tr>
<tr>
<td>Nicholas</td>
<td>Groneman, DMD</td>
<td>17531 S Golden Rd</td>
<td>Comfort Dental Golden</td>
<td>Golden</td>
<td>CO</td>
<td>80401</td>
<td>(303) 278-6953</td>
</tr>
<tr>
<td>Paulette</td>
<td>Porzio-Dilizia, DDS</td>
<td>17531 S Golden Rd</td>
<td>Comfort Dental Golden</td>
<td>Golden</td>
<td>CO</td>
<td>80401</td>
<td>(303) 278-6953</td>
</tr>
<tr>
<td>Matt</td>
<td>Carlston, DDS</td>
<td>881 N Federal Blvd</td>
<td>Comfort Dental Mile High</td>
<td>Denver</td>
<td>CO</td>
<td>80204</td>
<td>(303) 825-0013</td>
</tr>
<tr>
<td>First Name</td>
<td>Last Name, DDS</td>
<td>Address</td>
<td>Clinic Name</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Phone</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------</td>
<td>----------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------</td>
<td>-------</td>
<td>--------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Jim</td>
<td>Parfitt, DDS</td>
<td>881 N Federal Blvd</td>
<td>Comfort Dental Mile High</td>
<td>Denver</td>
<td>CO</td>
<td>80204</td>
<td>(303) 825-0013</td>
</tr>
<tr>
<td>Jashon</td>
<td>Hughes, DDS</td>
<td>16981 E Quincy Ave #D1-D3</td>
<td>Comfort Dental Quincy &amp; Buckley</td>
<td>Aurora</td>
<td>CO</td>
<td>80015</td>
<td>(303) 617-8400</td>
</tr>
<tr>
<td>James L</td>
<td>Liu, DDS</td>
<td>16981 E Quincy Ave #D1-D3</td>
<td>Comfort Dental Quincy &amp; Buckley</td>
<td>Aurora</td>
<td>CO</td>
<td>80015</td>
<td>(303) 617-8400</td>
</tr>
<tr>
<td>Trevor</td>
<td>Maxwell, DDS</td>
<td>16981 E Quincy Ave #D1-D3</td>
<td>Comfort Dental Quincy &amp; Buckley</td>
<td>Aurora</td>
<td>CO</td>
<td>80015</td>
<td>(303) 617-8400</td>
</tr>
<tr>
<td>John</td>
<td>Thousand III, DDS</td>
<td>16981 E Quincy Ave #D1-D3</td>
<td>Comfort Dental Quincy &amp; Buckley</td>
<td>Aurora</td>
<td>CO</td>
<td>80015</td>
<td>(303) 617-8400</td>
</tr>
<tr>
<td>Cory</td>
<td>Higginbotham, DDS</td>
<td>10350 Federal Blvd Unit 300</td>
<td>Comfort Dental Westminster</td>
<td>Federal Heights</td>
<td>CO</td>
<td>80260</td>
<td>(303) 427-2722</td>
</tr>
<tr>
<td>Hiba</td>
<td>Kellow, DDS</td>
<td>10350 Federal Blvd Unit 300</td>
<td>Comfort Dental Westminster</td>
<td>Federal Heights</td>
<td>CO</td>
<td>80260</td>
<td>(303) 427-2722</td>
</tr>
<tr>
<td>Mike</td>
<td>Mierzejewski, DDS</td>
<td>10350 Federal Blvd Unit 300</td>
<td>Comfort Dental Westminster</td>
<td>Federal Heights</td>
<td>CO</td>
<td>80260</td>
<td>(303) 427-2722</td>
</tr>
<tr>
<td>Helen</td>
<td>Stella, DDS</td>
<td>10350 Federal Blvd Unit 300</td>
<td>Comfort Dental Westminster</td>
<td>Federal Heights</td>
<td>CO</td>
<td>80260</td>
<td>(303) 427-2722</td>
</tr>
<tr>
<td>Darlyne</td>
<td>Loper, DMD</td>
<td>1279 West Littleton Blvd</td>
<td>Darlyne Loper, DMD</td>
<td>Littleton</td>
<td>CO</td>
<td>80120</td>
<td>(303) 794-3969</td>
</tr>
<tr>
<td>Thomas</td>
<td>Losacco, DDS</td>
<td>801 6th St</td>
<td>Family Dental Center III</td>
<td>Georgetown</td>
<td>CO</td>
<td>80444</td>
<td>(303) 569-3141</td>
</tr>
<tr>
<td>John</td>
<td>Burchfield, DDS</td>
<td>2007 Jackson</td>
<td>Golden Dental Care</td>
<td>Golden</td>
<td>CO</td>
<td>80401</td>
<td>(303) 279-3992</td>
</tr>
<tr>
<td>J Craig</td>
<td>Armstrong, DDS</td>
<td>1040 S Gaylord #103</td>
<td>J Craig Armstrong, DDS</td>
<td>Denver</td>
<td>CO</td>
<td>80209</td>
<td>(303) 777-6202</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Lee, DDS</td>
<td>10815 W Jewell Ave., Ste. L</td>
<td>Lakewood Smiles</td>
<td>Lakewood</td>
<td>CO</td>
<td>80232</td>
<td>(303) 988-6860</td>
</tr>
<tr>
<td>Efren</td>
<td>Martinez, DDS</td>
<td>1200 S Wadsworth #105</td>
<td>Martinez Dental</td>
<td>Lakewood</td>
<td>CO</td>
<td>80232</td>
<td>(303) 733-7533</td>
</tr>
<tr>
<td>Michael</td>
<td>Stiles, DDS</td>
<td>7350 Lowell Blvd</td>
<td>Michael J. Stiles, DDS</td>
<td>Westminster</td>
<td>CO</td>
<td>80030</td>
<td>(303) 428-6571</td>
</tr>
<tr>
<td>Lan Phuong</td>
<td>Nguyen, DDS</td>
<td>805 S Federal Blvd</td>
<td>South Federal Dentistry</td>
<td>Denver</td>
<td>CO</td>
<td>80219</td>
<td>(303) 935-2353</td>
</tr>
<tr>
<td>Lonnie</td>
<td>Johnson, DDS</td>
<td>13065 E 17th Ave Rm 310F</td>
<td>UCSDM</td>
<td>Aurora</td>
<td>CO</td>
<td>80045</td>
<td>(303) 724-7040</td>
</tr>
<tr>
<td>Steven J</td>
<td>Zapien, DDS</td>
<td>4331 Harlan St</td>
<td>Wheat Ridge Family Dentistry</td>
<td>Wheat Ridge</td>
<td>CO</td>
<td>80033</td>
<td>(303) 423-0584</td>
</tr>
</tbody>
</table>
**AFFIDAVIT FOR LAWFUL PRESENCE**  
**COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS**

I, ________________________________, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- [ ] I am a U.S. citizen.
- [ ] I am a legal permanent resident of the U.S.
- [ ] I am lawfully present in the U.S. pursuant to Federal law.

I understand that this sworn statement is required by law because I have applied for a “state public benefit,” as that term is defined under section 24-76.5-102(3), C.R.S. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under section 18-8-503, C.R.S. and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

**FOR INTERNAL USE ONLY**

Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document present in the applicant’s file.

- [ ] A valid Colorado driver’s license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless the applicant holds a license or card that states, “Not Valid for Federal Identification, Voting, or Public Benefit Purposes”, or
- [ ] Any out of State Driver’s license or ID card expired less than 10 years except from Alaska, Illinois, New Mexico, Utah, or Washington. (Note: Any driver’s license or ID card labeled “Enhanced” is acceptable), or
- [ ] A United States military card or a military dependent’s identification card, or
- [ ] A United States Coast Guard Merchant Mariner card, or
- [ ] A Native American tribal document, or
- [ ] A document listed in “LIST A” (for U.S. citizens and non-citizen nationals only), or
- [ ] Name of document accepted: __________________
- [ ] A document listed in “LIST B” (for non-U.S. citizens only).
- [ ] Name of document accepted: __________________ Date verified in SAVE: ________________

Please Note: If the applicant is a United States citizen or non-citizen national and is unable to present any of the documents listed on this form and seeking a Request for Waiver would impose unusual hardship, the applicant may submit a written declaration or a third-party written declaration. These options should be used with caution. The applicant must sign the next page.

**SELF DECLARATION**

I, ________________________________, self-declare and swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I am a United States citizen or non-citizen national.

Signature: __________________________ Date: ________________

**THIRD-PARTY DECLARATION**

I, ________________________________, swear or affirm under penalty of perjury, and possibly subject to later verification of status, that the attached written declaration(s) from one or more third-parties do have personal knowledge that I am a United States citizen or non-citizen national.

Signature: __________________________ Date: ________________

Last updated: December 3, 2014
ACCEPTABLE DOCUMENTATION FOR DETERMINING LAWFUL PRESENCE

LIST A (U.S. citizens or non-citizen nationals, only)

A. Primary Evidence (One document is needed): Identity can be proven by these same documents if they bear a picture.
   1. Copy of applicant's birth certificate from any state, the District of Columbia and all U.S. territories, or
   2. U.S. Passport, except for "limited" passports, issued for less than five years, or
   3. Report of Birth Abroad of a U.S. Citizen, form FS-20, or
   4. Certificate of Birth issued by a Foreign Service post (FS-545) or Certification of Report of Birth (DS-1350), or
   5. Certification of Naturalization (N-550 or N-570), or
   6. Certificate of Citizenship (N-560 or N-561), or
   7. U.S. Citizen Identification Card (I-97). Note: these were last issued in 1974, or
   8. Northern Mariana ID Card (issued to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands prior to November 3, 1986), or
   9. Statement provided by a US consular officer certifying that the individual is a US citizen, or
   10. American Indian Card with Classification code “KIC” and a statement on the back identifying US Citizen Members of the Texas Band of Kickapoo’s.

B. Secondary Evidence: If applicant cannot present one of the documents listed above, the following may be relied upon to establish US citizenship or nationality:
   1. Religious records recorded in one of the 50 states, the District of Columbia and U.S. territories, w/in three months after birth showing the birth occurred in such jurisdiction and the date of birth or the individual’s age at time the record was made, or
   2. Evidence of Civil Service Employment by the US Government before June 1, 1976, or
   3. Early school records (preferably from the first school) showing the date of admission to the school, the child’s date and place of birth and the names and place(s) of birth of the parent(s), or
   4. Census record showing name, U.S. citizenship or a U.S. place of birth and age of applicant or date of birth, or
   5. Any other documents that establish a U.S. place of birth or in some way indicates U.S. citizenship, or
   6. Written self-declaration or third-party declaration.

LIST B (Non-U.S. citizens and must be verified in SAVE)

1. Form I-551 ( Alien Registration Receipt Card, commonly called or known as a "green card"), or
2. Unexpired Temporary I-551 Stamp in foreign passport or on Form I-94, or
3. Form I-94 annotated w/stamp showing grant of asylum or under section 208 of the Immigration and Nationality Act (INA), or
4. Form I-688B (Employment Authorization Card) annotated “274a.12(a)(5)”, or
5. Form I-776 (Employment Authorization Document) annotated “A5”, or
6. Grant letter from the Asylum Office, or
7. Form I-94 annotated with stamp showing admission under Section 207 of the INA, or
10. Form I-571 ( Refugee Travel Document), or
11. Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA, or
12. Form I-688B (Employment Authorization Card) annotated 274a.12(a)(10), or
14. Order from an immigration Judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 241(b)(3) of the INA, or
15. Form I-94 with stamp showing admission under Section 203(a)(7) of the INA, or
16. Form I-688B (Employment Authorization Card) annotated "A3", or
17. Form I-766 (Employment Authorization Document) annotated “A3”, or
18. Form I-551 ( Alien Registration Receipt Card, known as the “Green Card”) with the code CU6, CU7, or CH6, or
19. Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CU6, CU7, or CH6, or
20. Form I-94 with stamp showing parole as “Cuba/Haitian Entrant” under Section 212(d)(5) of the INA.

NOTE: If an applicant has a disability that limits the applicant’s ability to provide the required evidence of immigration status (e.g., amnesia, or other cognitive, mental or physical impairment), you should make every effort to assist to obtain the required evidence.

Last updated: December 3, 2014