



Voucher Request

Applicant Information

Facility: _____ Date: _____

Full Name: _____
Last First M.I.

Address: _____
Street Address Room #

City State ZIP Code

Phone: _____ Email: _____

Date Available: _____ Social Security No.: _____ Room Number: _____

Type your dental service request here

Please note, emergency services are NOT available. If voucher request is approved, the applicant will be added to the next scheduled facility visit.

Requirements

To be eligible for our program, applicants must:

- Submit this application and a copy of the resident's face sheet to Info@SrDent.com
- Have household income at or below 200% of the U.S. Poverty guidelines.
- Not be eligible for Medicare Part A.
- Be a resident of a Long-Term Care Facility.
- Have no other resources available to them to pay for dental care, including federal or state programs or assistance from local charitable organizations.

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to a Service Voucher Issued, I understand that false or misleading information in my application may result in being billed for services being rendered.

Signature: _____ Date: _____