

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
MICHIGAN DENTAL PROGRAM APPLICATION**

NEW  
 RENEWAL

**FY 2014**



**DEMOGRAPHICS**

Name: \_\_\_\_\_

Date of Birth: _____	SSN: _____	Phone: _____
Current Address: _____		APT #: _____
City: _____	State: _____	ZIP Code: _____
Permanent <input type="checkbox"/> Homeless <input type="checkbox"/>	ADAP ID #: _____	MDP Patient #: _____

**RACE AND ETHNICITY**

Gender:  Female  Male  Transgender Unknown  Transgender M to F  Transgender F to M  Refuse to Report

Race		Ethnicity
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Pacific Islander/Hawaiian	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Native American	<input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

**INCOME / OTHER COVERAGE ELIGIBILITY**

Household size (including self, spouse, and/or dependents living with you): \_\_\_\_\_

Total Gross income (please attach most recent months proof of income): \$ \_\_\_\_\_

Do you have Medicare?	<input type="checkbox"/> Yes	<input type="checkbox"/> Part A/B	<input type="checkbox"/> Part D	<input type="checkbox"/> No
Do you have Private Health Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you applied for Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (please provide proof)		
Do you have Healthy Michigan Plan?	<input type="checkbox"/> Yes	Name of Plan: _____		<input type="checkbox"/> No
Do you have Private Dental Insurance?	<input type="checkbox"/> Yes	Name of Plan: _____		<input type="checkbox"/> No
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other Public: _____		

**HIV STATUS**

HIV Diagnosed on	AIDS Diagnosed on
Date: _____	Date: _____
<b>HIV STATUS</b>	<input type="checkbox"/> HIV Positive (Not AIDS) <input type="checkbox"/> CDC Defined AIDS
	<input type="checkbox"/> HIV-Negative (affected) <input type="checkbox"/> HIV-Indeterminate

**HIV STATUS, LABS MUST BE INCLUDED (LABS MUST BE WITHIN LAST 6 MONTHS AND SHOW A DETECTABLE VIRAL LOAD AND/OR POSITIVE/REACTIVE WESTERN BLOT.)**

Absolute CD4 Numbers/MM3: _____	Test Date : _____	Physician Signature: _____
HIV RNA Viral loads: _____	Test Date : _____	

Authority: PA 368 of 1978  
Completion: Is voluntary, but is necessary to receive coverage under Michigan Dental Program.

Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I understand that if I become enrolled in a dental insurance program that pays for any portion of my dental or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Michigan Dental Program (MDP) in addition to my dentist.

I authorize the MDP to receive, disclose, and discuss dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program representative, or other individuals as required and necessary. In addition, specific agencies and phone numbers are listed below.

I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that my assistance will be inactive until all the requirements are met.

I understand that if any of the information provided on this application changes that I must notify the MDP immediately.

The information that I have provided on this application is complete and true to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the instructions and have followed the necessary steps that are required for me to be on the Michigan Dental Program. In addition, I understand that failure to report changes and/or reporting of inaccurate information may affect MDP coverage and program eligibility.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

**AGENCY OR PERSON**

**PHONE NUMBER**

**Case Manager (Optional)** \_\_\_\_\_

**Dentist (Optional)** \_\_\_\_\_

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name of Applicant** \_\_\_\_\_

Print name

**Please allow 14 business days for processing for non-emergency cases**  
PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:

Michigan Dental Program  
109 Michigan Avenue, 8<sup>th</sup> Floor  
Lansing, Michigan 48913  
PHONE: (844) 648-3384  
Fax (517) 335-7723

<i>MDP office use only</i>	
<b>Confirmed MDP Coverage: DAP #</b> _____ - _____ - _____	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Healthy Michigan Plan <input type="checkbox"/> Michigan Resident <input type="checkbox"/> Income <input type="checkbox"/> Labs (Proof of Status)	Denied _____  Date __/__/____  Initials _____
Date __/__/____    Initials _____	

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