



**Serving Our  
Neighbors In Need**

800 Grand Ave  
Bacliff, Tx 77518  
office 281-339-3033  
fax 281-339-3032  
www.lighthousecm.org

To determine eligibility and to schedule an appointment with LCM's dental clinic, a patient must provide:

- Proof of residence in Bacliff, San Leon, Kemah, or Bayview; a rental agreement, a utility statement, etc.
- Proof of income for every member of the household who works:
  - Tax Return
  - Last 2 months of pay stubs
  - SSI Statement
  - Food stamp award letter
  - Disability award letter
  - Unemployment award letter
  - Any other income
  - If no income: Letter of support from family member or friend who is supporting them indicating the support they are receiving. The letter must be signed, have address, date, and be notarized.
- Photo ID
- A completed patient application form (attached)

**As a representative of Lighthouse Christian Ministries, I have reviewed the eligibility documents checked above and have determined that \_\_\_\_\_ is eligible to receive services at LCM's dental clinic:**

**Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



Screener \_\_\_\_\_ Date: \_\_\_\_\_  
 Qualified?  YES Tier: \_\_\_\_\_  NO

## Patient Application Form

Name: \_\_\_\_\_  
First Last

Dental Care is for:  SELF  CHILD(REN): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Soc. Sec. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ID: \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced  Separated Sex:  Male  Female

Race (OPT):  Caucasian  African-American  Hispanic  Asian  Other: \_\_\_\_\_

How many people in your household? \_\_\_\_\_ How many under 18? \_\_\_\_\_

Are you employed?  YES  NO  Full Time?  Part Time?  
 If yes, where? \_\_\_\_\_

Do you or anyone in your family have dental insurance?  YES  NO

Are you or anyone in your family receiving:

TANF  Food Stamps  Child Support  Medicaid  Medicare  SSI

Amount: \_\_\_\_\_ Amount: \_\_\_\_\_ Amount: \_\_\_\_\_ Amount: \_\_\_\_\_ Amount: \_\_\_\_\_ Amount: \_\_\_\_\_

Household Income:

Name of person receiving income	Name of employer, agency, or person who provides money	Amount Received (before taxes)	How often received? (daily, weekly, monthly)

Total Income: \_\_\_\_\_  
Annual/Monthly

Family Members:

Name (first, last)	Social Security #	Sex	Date of Birth	What relation to you

\*If application is for a child, please place an asterisk by patient's name.

Do you attend church?  YES  NO

If yes, where? \_\_\_\_\_

Things we can pray for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The statements in this form are true and correct to the best of my knowledge and belief.

I agree to give the eligibility staff at Lighthouse any information necessary to prove the statements about my eligibility. I also agree to allow them to contact and receive any information to verify the information listed above.

I agree to report any of the following changes within 30 days: income, resources, number of people who live with me, address, application for or receipt of SSI, TANF, Medicare and Medicaid.

I understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name



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## Patient Agreement

Lighthouse Christian Ministries is a 501c3, non-profit organization that desires to serve upper Galveston County by providing basic dental services to those that have no other means to obtain dental care. The clinic is staffed by volunteers who are not paid for their services.

To better serve you, we ask for your cooperation in following the policies listed below. If you are unable to follow these guidelines or find them unacceptable, another health care provider may be better able to meet your needs.

I understand and agree to the following:

- 1) I will inform LCM if my address, telephone number(s), income, or insurance changes no longer than 30 days after the change is made.
- 2) **I will give LCM at least 24 hour notice if I am unable to keep my appointment.**
- 3) **I understand that, if I miss an appointment without notifying LCM at least 24 hours prior to my appointment, I may no longer be able to receive dental services at LCM, and may have to reapply for dental services after a one (1) year waiting period.**
- 4) I understand that LCM does not provide comprehensive dental care and may not be able to meet all my dental needs. Services are limited to basic procedures such as fillings, extractions and cleanings.
- 5) I understand that services at LCM may be limited to 3-4 visits. After one (1) year my eligibility for services will expire.
- 6) I understand that a fee schedule will be used to determine my fee, and the fee will be due at the time of each service.
- 7) I understand that I am solely responsible for following through with instructions given by the dentist or hygienist after any procedures, and if I fail to follow these orders, my treatment may be unsuccessful.
- 8) I agree that my picture may be taken, and any photographs or video taken of me may be used for publicity purposes, and that any photos or video will be identified by first name only, if any names are used at all. \_\_\_\_ Please initial if you do not wish to participate.
- 9) I understand that if I am uncooperative, verbally or physically abusive, intoxicated, or behave in an inappropriate manner I may not be eligible for current or future services at LCM.

I have received a full explanation of LCM's clinic services and I understand and agree to all of the above. I understand I can be terminated from the clinic if I have given wrong or misleading information, or if I fail to follow the policies above.

Signature of Patient or Parent or Guardian: \_\_\_\_\_

Name of Patient (Printed): \_\_\_\_\_ Date: \_\_\_\_\_