Serving Our Neighbors In Need
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To determine eligibility and to schedule an appointment with LCM's dental clinic, **a patient must provide**:

- Proof of residence in Galveston County; a rental agreement, a utility statement, etc.
- Proof of income for every member of the household who works (one of the following):
    - 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: ____

Patient Application Form

Why do you need to see the Dentist? ____

How did you hear about us? ____

Name: ____
First Last

Mailing Address: ______________________________ Apt:_______ City:________________________ Zip: _______________

Home Phone: _________________________ Work Phone: _________________________ Cell Phone: _________________________

E-Mail: ____

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 any of the following?

□ 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 authorize Lighthouse Christian Ministries, as a CharityTracker Participating Agency, to share my basic, identifying and non-confidential service transactions/information with other CharityTracker Participating Agencies. I authorize the use of a copy of this original to serve as an original for the purposes stated above.

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

Screener__________________________ Date:________

Qualified? ☐ YES Tier: ________ ☐ NO

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:____________________