"Young Tahoe Smiles"

Screening

"Young Tahoe Smiles" will subsidize basic dental care for children who meet the eligibility criteria established by the program. The dental care consists of diagnostics, preventive and basic restorative treatment. "YTS will make the determination as to what specific treatment each child will receive and the maximum that will be allotted to each individual case. The Program's available funding is limited and services will be provided to qualifying children as long as the Program has the funds to do so."

The goal of the program is to restore children's oral health to a stable, infection free, pain free and functional state.

"Young Tahoe Smiles" program is located and offered through and at High Sierra Dental Care 1060 Ski Run Blvd, South Lake Tahoe, CA, 96150. (530) 541-7040

Screening process:
In order to determine eligibility and qualify for the "Young Tahoe Smiles" program, please complete the information on the back of this sheet.

In addition, please provide, pay stubs, W2, or last years tax returns, plus any other information you would like us to take into consideration.

Eligibility Criteria:
1. Financial Criteria: Children and their immediate family must not have dental insurance to cover the necessary services. The immediate family must meet federal poverty guidelines.
2. Children must be 6 to 16 years of age and must not qualify for any other insurance or assistance program available to them at the time of eligibility screening.
3. Compelling exceptions to the eligibility process will be considered on a case by case basis. Criteria considered will include but not be limited to: Income, necessity of dental services and ramification of failure to receive dental treatment.
4. This program will not discriminate on the basis of, gender, race or religion.

Parental Obligations:
1. The parent(s), or guardian(s) must commit to bringing the child to his or her appointments on time.
2. Missing an appointment is cause for immediate dismissal from the program regardless of the reason or excuse for absence.
3. The program is limited to morning appointments
4. The parent(s) or guardian(s) agree to pay the fee of $5.00 to $10.00 per visit at the time services are rendered. The fee is assessed based on financial circumstances.

Once all the requested information is provided families will receive and answer within one business day.

We look forward to working with you in order to improve the oral health of our children.

My signature below indicates my acceptance to provide the requested information and confirms my child/children do not have or qualify for any other dental insurance or assistance.

Parent/Guardian Signature_____ Date_____

Phone numbers: home_____ cell_____