

To Qualify You Must:

- Currently live in one of the following counties:
South Central Idaho: Blaine, Camas, Cassia, Elmore, Gooding, Jerome, Lincoln, Minidoka, or Twin Falls
Southwest Idaho: Canyon, Gem, Payette, or Washington
- Be between **age 60 - 79**
- Have a household income within the ranges shown in the income chart (on the back page)
- Be independently mobile and able to travel to dental offices for treatment within 60 days of being accepted into the program
- Submit proof of income

To Apply:

- Complete and sign this application
- Send a copy of the first page of your last completed federal income tax return as proof of income (IRS 1040, 1040A or 1040EZ)
- If you do not file income taxes you may submit a copy of your Social Security award letter or benefit statement
- By May 29th, 2015 mail application and proof of income to:
 Delta Dental of Idaho Community Outreach
 PO Box 2870
 Boise, ID 83701

If more than one person in your household is applying, you may send completed applications and tax forms together

PLEASE PRINT CLEARLY

First Name:		MI:	Last Name:		Date of Birth:
Social Security Number:			Phone Number: (with area code)		
Gender: M/F	E-mail Address:				
Mailing Address:			City:	State:	Zip:
Number of people in your household:		Gross Monthly Income:		Gross Yearly Income:	

Are you currently in any of the following programs?

- Food Stamps
- Low-Income Home Energy Assistance Program (LIHEAP)
- Medicaid
- Supplemental Security Income (SSI)

If the *GrinWell for You* program is full, would you like to be placed on a waiting list?

- Yes
- No

Questions? Call us toll free at 1-866-894-3563

Income Chart:

Ages 60-64 Household Income Limits (Effective January 2015)		
Household Size ⁱ	Gross Yearly Income Range	Gross Monthly Income Range
1	\$23,737 or less	\$1,979 or less
2	\$31,995 or less	\$2,667 or less
3	\$40,253 or less	\$3,356 or less
4	\$48,511 or less	\$4,043 or less
For households with more than 4 people, add \$8,258 yearly or \$688 monthly for each additional person ⁱ Household size is defined as you, your spouse, and any dependent children		
Ages 65-79* Household Income Limits (Effective January 2015)		
Household Size ⁱ	Gross Yearly Income Range	Gross Monthly Income Range
1	\$9,614 to \$23,737	\$801 to \$1,979
2	\$12,958 to \$31,995	\$1,081 to \$2,667
3	\$16,303 to \$40,253	\$1,359 to \$3,356
4	\$19,648 to \$48,511	\$1,638 to \$4,043
For households with more than 4 people: <ul style="list-style-type: none"> • Yearly add: \$3,345 to the lower range and \$8,258 to the upper range • Monthly add: \$279 to the lower range and \$688 to the upper range ⁱ Household size defined as you, your spouse, and any dependent children *If your gross income is below the \$9,614 yearly or \$801 monthly limit you likely qualify for dental benefits through Idaho Medicaid and therefore you are not eligible for the <i>GrinWell for You</i> program		

Application Agreement:

I hereby apply for coverage through the Delta Dental *GrinWell for You* program. I understand that this application will be accepted only if I meet the eligibility requirements. If accepted, I understand:

- The \$1,250 in coverage will be provided only for services available under the *GrinWell for You* program and that I am responsible for any services I agree to that are not covered by the program
- The \$1,250 in coverage will be provided for 2015 only
- Enrollment is limited to 300 participants
- I must visit a participating dentist within 60 days of being accepted into the program

I hereby certify that all the information contained in this application is true and correct to the best of my knowledge.

 Applicant Signature

 Date

- Please check here if you are willing to share your dental need story to help us promote and spread the word about the *GrinWell for You* Program (not required to participate in the program).

For office use only: Eligible Date: _____ Ineligible Reason: _____ Date: _____