OAKLAND COUNTY HEALTH DIVISION
APPLICATION FOR DENTAL PROGRAM
1200 N. Telegraph Road, Bldg. 34 East
Pontiac MI 48341
(248) 858-1306
(888) 350-0900 ex 81306 Toll Free

PLEASE READ CAREFULLY:
The Oakland County Dental Program is available for Oakland County residents with no dental insurance and are income eligible. Military veterans will be given priority.

Eligibility is based on total household income and the number of family members.

*Applicants with no income will need to provide proof that Medicaid was denied by the Michigan Department of Health and Human Services with this application.*

You will be notified by mail as to your eligibility and the next steps for enrollment.

## PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME: _____
(Last) (First) (Middle Initial)

RESIDENCE: _____
(# and Street) (City) (Zip Code)

PHONE: _____
(Home) (Cell) (Other)

DATE OF BIRTH: _____ Sex: ☐ Female ☐ Male ☐Transgender

**Race: (which you most closely identify with)**
☐American Indian/Alaskan Native
☐Asian
☐Black/African American
☐Hawaiian /Pacific Islander
☐White/Caucasion
☐Other

**Ethnicity 1**:
☐Hispanic/Latino
☐Non-Hispanic/Latino

**Ethnicity 2:**
☐Arab Descent
☐Non-Arab Descent

## *SEE REVERSE SIDE*

The Oakland County Health Division will not deny participation in its programs based on race, sex, religion, national origin, age or disability. State and Federal eligibility requirements apply for certain programs.

PLEASE LIST ALL FAMILY MEMBERS THAT LIVE WITH YOU (attached additional page if needed)

| LAST NAME | FIRST NAME | RELATIONSHIP TO YOU | BIRTHDAY MO/DAY/YR | DENTAL INSURANCE? YES/NO | MONTHLY INCOME |
|---|---|---|---|---|---|
| | | ***SELF*** | | | |
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Please include the following:

1. Copy of your most recent Federal Income Tax Form 1040 pages 1 & 2 only
   ☐ I was exempt from filing a Federal Income Tax Return
2. Proof of last month's total income* for all family members, such as:
   - Employment pay statements
   - Unemployment statements
   - Social Security and/or SSI benefits
   - Other retirement income (pension, IRA, annuities)
   - Any other source of income: Submit any documentation you have that proves the monthly amount you receive and the source of income

   *** Please note that as of 2026, Veterans applying or reapplying to the program are now required to provide proof of income.**

3. Proof of Oakland County residency (Driver's License, MI photo ID, utility bill with your name and address, etc.)
4. If you have a Medicare Advantage Plan: Medicare ID_____ and

   Advantage Plan Type & ID:

   _____.
5. Military veterans include VA card or some form of military identification.
6. **If you do not have any income, please include a determination letter from the Michigan Department of Health & Human Services showing approved or denied benefits.**

We may call you to seek further clarification or additional information.

By signing below, you attest that the information given in this application is true, accurate and complete.

Applicant's Signature_____ Date: _____

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