Vancouver Community Public Health Dental Program
Robert and Lily Lee Family Community Health Centre
#210 – 1669 East Broadway, Vancouver, BC V5N 1V9
Telephone: 604-675-3981 Facsimile: 604-872-0108

PUBLIC HEALTH DENTAL PROGRAM
PATIENT ELIGIBILITY APPLICATION FORM

☐ New Application Verified by:

☐ Renewal Date:

PART I – ELIGIBILITY CRITERIA

To be eligible you *must*:

- Reside in Vancouver.
- Have dependent child(ren) Grade 7 or under.
- Meet financial criteria.

PART II – DENTAL INSURANCE COVERAGE

Do you, your spouse/common-law partner, or dependent children currently have dental insurance?

☐ Yes ☐ No ☐ Do not know

PART III – PARENT/GUARDIAN INFORMATION (Please Print)

Last Name	**First Name**	**Middle Name**
Telephone Number	**Daytime Telephone Number**	

Home Address

Street: _____ Apartment #:_____City:_____

Province:_____ Postal Code: _____

E-mail address: _____

Consent to text: ☐ Yes ☐ No

Consent to use e-mail: ☐ Yes ☐ No

Identification: Parent/Guardian must provide one piece of Photo ID

☐ Driver's License ☐ Passport ☐ Other: _____

A copy of the Photo ID must be provided with this application and an original must be presented at first appointment.

Address Confirmation: Minimum of ONE must be provided

☐ Driver's License ☐ Utility Bill ☐ Bank Statement

☐ Other: _____

A copy of one of the above must be provided with this application and an original must be presented at first appointment.

PART IV – DEPENDENT INFORMATION (Please Print)

Dependents: Eligibility for the dental clinic is restricted to children Grade 7 or under, however, please include all other minors (under 19 years of age) as well as dependent post-secondary students (19-24 years of age) or any dependent adults.

Please attach copies of 2 pieces of identification (**one must be a BC Services Card and a Birth Certificate or Passport**) for each eligible child listed below. If more space is required, please attach a separate sheet.

Child's Legal Name	Date of Birth (Day/Month/Year)	Gender (Male or Female)	BC Services Card Number	Does your child have any dental pain (Yes or No)

PART V – TOTAL ANNUAL NET INCOME

Please provide a copy of your most recent Income Tax return(s), Canadian Revenue Notice of Assessment(s) or GST Credit for parent/guardian (and spouse or common-law partner if applicable).

Are you living with a spouse or common-law partner?

☐ Yes ☐ No Name of spouse or common-law partner:_____

1. Parent/Guardian's income		**← (Line 236 of Canadian Revenue Notice of Assessment, Income Tax Return or GST Credit from previous year)**
2. Spouse or common-law partner's income (if applicable)		**← (Line 236 of spouse's or common-law partner's Notice of Assessment or Income Tax Return from previous year)**
Total combined net income from previous year		**← Add lines 1+2**

PART VI – DECLARATION AND CONSENT

I/We declare that the information provided on this application is accurate and true to the best of my/our knowledge.

I/We understand that giving false or incomplete information may result in termination or suspension of service.

I/We understand that this information will be used to determine eligibility for dental services.

I/We understand that Healthy Kids plan eligibility may change and coverage will be confirmed monthly.

I/We understand the Vancouver Public Health Dental Program does not bill all private dental insurance plans.

I/We understand that we will need to reapply annually to establish eligibility.

I/We understand there is a Cancellation/Broken Appointment policy and a $25 fee may be charged if appointments are not cancelled in a timely manner.

Name of Applicant (please print)	Name of Spouse/Common-law partner if applicable (please print)
Signature of Applicant	Signature of Spouse/Common-law partner (if applicable)
Date	Date

Please e-mail, fax, mail or drop off the forms in person:

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