Seminole County Community Services Department | COMMUNITY ASSISTANCE

Dental Assistance Program



The Community Assistance Office will provide Dental Assistance to income eligible Seminole County residents. The purpose of the Dental Assistance program is to provide financial assistance to adult Seminole County residents with deep cleanings, extractions, fillings, partial/full dentures, referral costs, root canals and crowns.

To be eligible for this program, the applying household must meet the minimum criteria below:

- **Household must reside in Seminole County.**
- **Household income must be at or below 120% of the current Area Median Income.**
- **The person applying for assistance must be at least 18 years of age or older.**

When the pre-application is reached on the waiting list, the following documents will be requested to determine eligibility:

- **Completed application**
- **Valid Florida ID or valid Florida Driver's License for all adults (18yrs and older).**
- **Birth certificates and social security cards for all household members.**
- **Third party verification of all household income and assets is required for this program.**
- **Valid Lease Agreement, Mortgage statement, or proof of homeownership.**
    - **Homeless Customers can complete the signed Homeless Affidavit Form**
- **Current utility bill (water, electric, or gas)**
- **Dental referral written by a licensed Central Florida dentist within the last 6 months.**

120% of Area Median Income (Updated October 2020)

1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
$61,080	$69,840	$78,600	$87,240	$94,320	$101,280	$108,240	$115,200

Pre-applications will be accepted from income-eligible households beginning February 1, 2021, Monday - Friday between the hours of 8 a.m. – 5 p.m. in the Seminole County Community Services Office at 534 West Lake Mary Boulevard; Sanford, Florida 32773. Only forty (40) pre-applications will be accepted on a first-come, first accepted basis. The pre-applications will be used to establish a waiting list for the Seminole County Dental Assistance Program. Assistance will be available in mid-March; please be sure not to have any dental work completed prior to County approval.

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

COMMUNITY ASSISTANCE DIVISION
534 West Lake Mary Blvd | Sanford, FL 32773 | 407-665-2300
www.SeminoleCountyFL.gov/comsrvs/

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Community Assistance Dental Pre-application

Head of Household	Phone #		Date of Birth	Age
Address	Apt. #	City, Zip Code	Alternative Phone #	
Co-Head of Household	Phone #		Date of Birth	Age

Additional Members in Household

(If necessary, use additional paper for more household member names)

Name(s)	Social Security #	Date of Birth	Age	Relationship
1				
2				
3				
4				

Gross Monthly Household Income

(Total Before Taxes)

Employment $	Social Security $
Unemployment $	SSI / SSD $
Workers Comp $	Public Assistance $
Pension/Retirement $	Life Insurance/Annuity $
Child Support $	Other $
	TOTAL $

All programs are open to all without regard to race, color, national origin, sex, handicap, familial status, or religion. Assistance is provided according to the availability of funding; some restrictions apply.

I certify that all information I have provided above is true and correct. I/we understand that Florida Statute 817 provides that willful false statements or misrepresentation concerning income; asset or liability information relating to financial condition is a misdemeanor of the first degree, punishable by fines and imprisonment provided under Statutes 775.082 or 775.083. I/we further understand that any willful misstatement of information will be grounds for disqualification. I/we certify that the application information provided is true and complete to the best of my/our knowledge. I/we consent to the disclosure of information for the purpose of income verification related to making a determination of my/our eligibility for program assistance. I/we agree to provide any documentation needed to assist in determining eligibility and are aware that all information and documents provided are a matter of public record. I/we further understand that if any misrepresentation or fraudulent statement is discovered after assistance has been provided the County will demand and pursue through all legal remedies available, repayment of the funds provided for the assistance that was provided.

Head of Household Signature:_____ Date:_____

COMMUNITY ASSISTANCE USE ONLY:

CUSTOMER SERVICE REPRESENTATIVE: _____

CASE MANAGER: _____

OUTCOME: _____

TIME/DATE STAMPED:

upup 4/20016