Wyoming Delta Dental Foundation

Wyoming Smiles Senior Dental Program
Application for Coverage - 2025

If more than one person in your household is applying, you MUST each submit your OWN application.

You can send separate completed applications and forms together.

To Apply:

1) Complete and sign this application (one application per person applying)
2) Send copies of proof of income
3) Send a readable copy of your ID (if you were on the program previously, you do not need to send a copy of your ID)
4) Mail your application and proof of income no later than December 13, 2024, to:

Wyoming Delta Dental Foundation
Wyoming Smiles Senior Dental Program
6705 Faith Drive
Cheyenne, WY 82009

Applications are processed in the order that they are received!

First Name:	MI	Last Name:	Date of Birth:

Mailing Address:	City:	State:	Zip:
		WY	

Social Security Number:	Phone Number:	Gender:	Number of people in your household:

Email Address:	Gross Monthly Household Income:	Gross Yearly Household Income:

Do you currently have dental insurance or any dental coverage, such as dental through your Medicare plan?

☐ Yes ☐ No

If you have other coverage, please explain what type and what is covered. (If not sure, please call us!)	Do you currently have a full set of upper and lower dentures? ☐ Yes ☐ No

To qualify you must:

Turn Application Over & Sign →

- Be a resident of Wyoming, living in Wyoming.
- Be age 65+.
- Have a household income within the range shown on the income chart.
- Submit proof of income.
- Be able to travel to a dental office for treatment within 90 days of being accepted into the program.
- Must not have any current dental insurance including Medicare Advantage or be enrolled in any program providing free dental care.

Application Agreement:

I hereby apply for coverage through the Wyoming Smiles Senior Dental program. I understand that enrollment in this program is limited, and I may be placed on a waiting list. Being placed on the waiting list does not ensure I will be placed on the 2025 program.

I understand that this application will be accepted only if I meet the eligibility requirements, if there is space available in the program and if I have no other dental benefits being provided to me or any dental insurance. If I have insurance and do not indicate that I do, I will be terminated from the program. If accepted, I understand I will be placed in one of three programs based on my eligibility.

If accepted, I understand I will be enrolled only for the 2025 program which runs from January 1, 2025 to December 31, 2025. If I am placed on the waiting list and am then enrolled, my eligibility start date may be later than January.

I must visit a WYOMING participating dentist. If I visit a dentist that does not participate or is outside of the state of Wyoming, I will be responsible for the cost of the visit.

I must visit a Wyoming participating dentist within 90 days of being accepted into the program or provide proof that I have been seen prior to my enrollment. If I cannot visit a dentist due to scheduling or health I will make the Wyoming Delta Dental Foundation aware. If I do not visit a dentist, provide proof I have seen one or contact the Wyoming Delta Dental Foundation about my situation, I may be removed.

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 the Wyoming Smiles Senior Dental program (This is NOT required to participate in the program).

Income Chart (Household income limits effective 1/1/2024)

Household Size	Gross Yearly Income	Gross Monthly Income
1	$30,120	$2,510
2	$40,880	$3,407
3	$51,640	$4,303
4	$62,400	$5,200

QUESTIONS?

CALL US AT 307-632-3313 OR 800-735-3379

Mail your completed application, along with your proof of income and copy of your identification to:

Wyoming Delta Dental Foundation
ATTN: WY Smiles Senior Dental Program
6705 Faith Drive, Cheyenne, WY 82009

For WY Delta Dental Foundation use only:

Eligible date: _____ Ineligible Reason: _____ Initials: _____ Date: _____