DELTA DENTAL

United Way

United Way of the Plains

Delta Dental of Kansas Community Benefit Plan

Agency Confirmation

Please confirm the individual(s) applying meets the eligiblity requirements as set-forth below. Also, provide your contact information.

Beth Oaks will verify eligibility and notify the agency contact of approval/denial.

Agency Contact

Contact Name: _____ Agency Name: _____

Phone Number: _____ Email Address: _____

Address: _____ City: _____, Kansas ZIP: _____

Eligibility

☐ Family Income: Less than or equal to 250% of the federal poverty line. (Attach income verification.)

☐ Employment: Head of household is employed. Include information on the Enrollment Form.

☐ Lack of Dental Insurance: Confirmation individual/family does not have access to dental insurance by more traditional means (e.g. employer-supplied insurance, eligibility as a dependent).

Please submit this completed form along with

- ☐ Income Verification
- ☐ Enrollment Form
- ☐ Consent to Release Information Form

to Beth Oaks at United Way of the Plains:
boaks@unitedwayplains.org or fax to 316.267.0937