



Jewish Family Service  
of Lackawanna County

615 Jefferson Avenue  
Suite 204  
Scranton, PA 18510  
(570) 344-1186  
Fax (570) 344-7641  
jsoflackawanna.org

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DATE

Dear Applicant:

You have applied for dental care at the Jewish Family Service of Lackawanna County Free Non-Sectarian Dental Clinic. In order to establish your eligibility for care at the clinic, it will be necessary for you to complete the enclosed application and return it with the following required documents:

- ⇒ Copy of last W-2 Form/Social Security Notice
- ⇒ Pay stubs for the past 2 months
- ⇒ Latest rent receipt
- ⇒ Copies of your current utility bills
- ⇒ Current statements of your loans/debts
- ⇒ \$5.00 Application Fee to be made payable to **Jewish Family Service**. *Please do not send cash.* Check or money order acceptable.

Your application will be delayed in processing if the requested information is not enclosed. Please sign and date the Patient Agreement included. You may contact our office at 344-1186 with any questions or concerns regarding our clinic application or services.

*JEWISH FAMILY SERVICE*

**OF LACKAWANNA COUNTY**

*615 Jefferson Ave.  
Scranton, PA 18510  
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**FOR OFFICE USE ONLY**

Case No. \_\_\_\_\_  
Eligibility Date: \_\_\_\_\_  
Redetermine Date: \_\_\_\_\_  
Date Sent: \_\_\_\_\_

**FREE NON-SECTARIAN**

**DENTAL CLINIC APPLICATION**

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_  
Last First Middle

**ADDRESS:**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip County

Length of time at above address: \_\_\_\_\_

**TELEPHONE:** Home: \_\_\_\_\_ Work: \_\_\_\_\_

**HOW DID YOU FIND OUT ABOUT OUR SERVICES** \_\_\_\_\_

**LIST ALL PEOPLE IN HOUSEHOLD (INCLUDING SELF):**

Name	Date of Birth	Relationship	Social Security Number	Access Card	Check If Dental Care Is Needed

**Have you applied for Medical Assistance:** \_\_\_\_\_ **If denied, copy of letter is needed.**

**Do you have Health Insurance:** \_\_\_\_\_ **Name of Insurance Company:**

\_\_\_\_\_ **Is Insurance through your employer:** \_\_\_\_\_

**Do you have the option to purchase Dental Insurance through your employment:** \_\_\_\_\_

**CURRENT MONTHLY INCOME:**

Name(s)	Gross	Net	Employer Name & Address	Length of Employment

If no income are you currently seeking employment: \_\_\_\_\_ If not, Why: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**FINANCES - SAVINGS ACCOUNT(S)**

1) Bank Name & Branch \_\_\_\_\_  
Account No. \_\_\_\_\_ Current Balance: \_\_\_\_\_

2) Bank Name & Branch \_\_\_\_\_  
Account No. \_\_\_\_\_ Current Balance: \_\_\_\_\_

**FINANCES - CHECKING ACCOUNT(S)**

1) Bank Name & Branch \_\_\_\_\_  
Account No. \_\_\_\_\_ Current Balance: \_\_\_\_\_

2) Bank Name & Branch \_\_\_\_\_  
Account No. \_\_\_\_\_ Current Balance: \_\_\_\_\_

**LIST ANY ADDITIONAL FORMS OF FINANCES, IF APPLICABLE: \_\_\_\_\_**

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**PLEASE LIST WHAT TYPE OF DENTAL CARE IS NEEDED FOR EACH MEMBER OF THE HOUSEHOLD REQUESTING CARE:**

Name	Type Of Care	Type Of Treatment Last Received	By Whom/Date

**ADDITIONAL INFORMATION:**

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*(Use additional paper if necessary)*

**JEWISH FAMILY SERVICE DENTAL CLINIC**

**PATIENT AGREEMENT**

*OUR CLINIC IS STAFFED BY VOLUNTEER DENTISTS FROM THE SCRANTON DISTRICT DENTAL SOCIETY AND IS AVAILABLE FOR LACKAWANNA COUNTY RESIDENTS ONLY. YOUR COOPERATION WITH THE FOLLOWING RULES IS FOR THE BENEFIT OF ALL PROVIDERS AND USERS OF OUR DENTAL CLINIC, ALIKE.*

1. When appointments are assigned, they must be kept unless unforeseen difficulties arise such as illness, bad weather, or emergencies.
2. If an unforeseen difficulty happens, that you are unable to keep your appointment, you **MUST** contact the dentists office as soon as possible to cancel your appointment. ***If you do not cancel your appointment prior to the appointment time you will be excluded from the program.*** You must also contact Jewish Family Service office to inform them of any change in appointments. The dentists from the Scranton Lackawanna County District Dental Society volunteer their services to help those in need with no remuneration for themselves, therefore it is imperative that you keep your appointment.
3. Appointments will be scheduled only through Jewish Family Service staff (i.e., Executive Director, secretary, social worker or dental assistant) according to the availability of dentists.

**I hereby certify that, to the best of my knowledge, the information contained herein is true, correct and complete. I have read the above rules and agree to them. I understand that failure to comply with the above rules may deem me ineligible for clinic services. I also understand that if special circumstances exist that cause me to be unable to pay the required application fee, I can contact the office for fee review with the Executive Director.**

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_