CLINTON COUNTY VETERANS SERVICE COMMISSION
43 S. WALNUT STREET
WILMINGTON, OHIO 45177

Dental Assistance Application

The Dental Program is to promote good oral hygiene and overall health through connecting Veterans with a local dentist in the community. One voucher will be issued annually to approved Veteran.

Services Offered include:

- Basic Annal Examination.
- Basic Dental Cleaning.
- Wing Bite X-Ray (if recommended).
- Panoramic X-Ray (if recommended).
- Fluoride Treatment (if recommended).

Veterans must choose a dentist from a provided list of participating Clinton County Dentists. Should an appointment be made and you fail to show without proper cancellation, you may be denied future dental and financial assistance.

Please provide the following:

- A copy of all your DD-214(s) / DD-93(s) unless previously provided. You must have an honorable or under honorable (General) character of service, which must be visible on the DD-214 / DD-93 copy.
- Proof of residency of Clinton County for at least 90 days. (ie., utility bill with your address).
- A copy of your current (not expired), valid Ohio photo identification.
- A copy of your Clinton County Veterans ID Card.
- Proof of Income (tax return or current pay stubs, all other income, VA compensation).
- Signed Liability Release Form.

INCOMPLETE APPLICATIONS WILL NOT BE APPROVED

***************************** For Internal Use Only *****************************

Last date of service at CCVSC ____________________________

Date of benefit review appointment ____________________________

Is the Veteran Eligible for additional VA Benefits? Yes or No

Are all required document on file? Yes or No

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DENTAL PROGRAM WAIVER AND RELEASE

By signing this form, I understand that I am waiving, releasing, and agree to hold harmless, the Clinton County Veterans Service Commission from any liability arising from or related to my participation in the CCVSC Dental Assistance Program. This includes by is not limited to any and all of the following:

{ INITIAL NEXT TO EACH LINE }

_____ Liability for any dental procedure performed by the dental care provider.

_____ Costs, fees, or other related expenses associated with my dental care beyond those paid for by the CCVSC.

_____ Any fees or costs charged by the dental care provider for missed appointments.

_____ Any follow up treatments recommended by the dental care provider which are not covered by the CCVSC Dental Assistance Program.

_____ Scheduling, attending, and coordinating my dental care appointments with the dental care provider.

By initialing the above items and signing below, I acknowledge that I have read, reviewed, and understand all of the terms of the CCVSC Dental Assistance Program and I am releasing any and all claims, either now or in the future, against the CCVSC as a participant in the CCVSC Dental Assistance Program.

____

Print Name Date

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Signature

____

Witnessed