PRINT

Peter K. Domoto Fund for Children Application

University of Washington School of Dentistry • Department of Pediatric Dentistry

Domoto Fund for Pediatric Dentistry: This fund is intended to cover costs of dental care in The Center for Pediatric Dentistry for patients up to the age of 19 who do not qualify for Medicaid (Apple Health) and who are uninsured or underinsured. Treatment will provide important educational opportunities for University of Washington Pediatric Dentistry Residents.

ORTHODONTIC CARE IS NOT COVERED.

Children whose applications are accepted will be seen as clinic capacity allows.

INSTRUCTIONS TO APPLY FOR THE DOMOTO FUND FOR CHILDREN:

1. Provide documentation that you applied for Apple Health and your children are not eligible. To apply call 1-800-756-5437.

2. If you do not qualify for Apple Health, complete this application.

3. Send 1) completed application, 2) documentation that you applied for Apple Health and your children are not eligible, and a 3) copy/scan or photo of household income paystub(s) for last 30 days.

4. Eligibility is determined by application completion, income guidelines (up to 410%of Federal Poverty Levels) and treatment needs. Please allow 5-7 business days to receive notification of application determination.

   Email forms to Klarissa Fellows, cpdreferral@uw.edu*, OR FAX to 206-543-0063. Forms may also be mailed: to: 6222 NE 74th St. Seattle, WA 98115. Questions? Call 206-543-9388.

   *Please consult our referral email policy.

This fund was established to honor Dr. Peter K. Domoto, Chair Emeritus of the University of Washington, Department of Pediatric Dentistry. Dr. Domoto dedicated his career to providing oral health care to children with limited access to care. REV 1/10/2017

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ANSWER THE FOLLOWING QUESTIONS:

- How many people in your household (including yourself)? ____
- What is your gross monthly household income? _____
- Do(es) child(ren) have dental insurance? ☐ No ☐ Yes If yes, name insurance company._____

HOUSEHOLD INFORMATION:

Adult 1: _____ Relation:_____

Email: _____ Phone: _____

Address:_____

Employment: Work full-time ☐ Work part-time ☐ Self-Employed ☐ Unemployed ☐

Student Interpreter needed? ☐ No ☐ Yes Language preference: _____

Adult 2: _____ Relation:_____

Email: _____ Phone: _____

Address: _____

Employment : Work full-time ☐ Work part-time ☐ Self-Employed ☐ Unemployed ☐

Student Interpreter needed? ☐ No ☐ Yes Language preference: _____

CHILD/CHILDREN INFORMATION:

First Name: _____ Last Name: _____ DOB: _____

First Name: _____ Last Name: _____ DOB: _____

First Name: _____ Last Name: _____ DOB: _____

First Name: _____ Last Name: _____ DOB: _____

OPTIONAL INFORMATION FOR CONSIDERATION (please write any additional information you would like to provide):

Applicant Signature: _____Date: _____

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Received Date: _____

Is child eligible for Medicaid? __ No __Yes Is family income 210-410% of federal poverty level? __ No __Yes

Financial eligibility: **Approved? ____ Denied? ____ *Date:_____**

If approved, the Domoto Fund coverage is:

Coordinator Signature: _____Date: _____

Approved by: _____Date: _____

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