New Hampshire
DENTAL SOCIETY
Professional Denture Care Program

603.225.5961
23 So. State St. | Concord, NH
03301
www.nhds.org

Thank you for your interest in the Professional Denture Care Program. The New Hampshire Dental Society established this program in 1980 to help provide professional care and services for full dentures to New Hampshire citizens of limited financial means. Patient eligibility standards were established on an income basis related to the number of persons in the household.

If you are not participating in any other program (s), are not utilizing a benefit through New Hampshire Medicaid for your dentures and are living on a low and/or fixed income, you may qualify to purchase dentures at a reduced fee through NHDS. Fees for this program assist to cover the lab expenses of the dentists who donate their services and time.

SERVICES

Services are limited to full dentures only. Partial dentures, immediate dentures, relines or extractions are not covered under this program.

FEES

Upper or Lower Dentures: $700 each
Upper & Lower Dentures: $1400 for both

To find out if you are eligible for this program, download & complete the application form and return it with income verification to:

New Hampshire Dental Society
23 South State Street
Concord, New Hampshire 03301

Please reach out with any questions - we look forward to helping you get your smile back!

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Application

603.225.5961
23 So. State St. | Concord, NH 03301
www.nhds.org

Please complete the below information to the best of your ability. *Please note that you will be expected to provide proof of all benefits for yourself and any other people residing in the same domicile.* If an application is received incomplete, it will be returned as it was received with a note indicating what is still needed to determine eligibility for the program. Applications will be returned once. If at any time you have questions regarding application process, please call the New Hampshire Dental Society at 603-225-5961.

CENTRAL OFFICE USE ONLY:

Date Received: _____ Date Returned: _____ Date Accepted: _____ Date Rejected: _____

Applicant Information

Full Name _____
Date of Birth _____ Phone _____ Email _____

Services Needed: (Circle all that apply)

First Upper Denture First Lower Denture Replacement Upper Denture Replacement Lower Denture

Have you had FULL extractions? Please indicate date of precedure: _____

Current Address

Address _____

_____

Rent or Mortgage Amount _____
Landlord/Property Manager _____ Phone _____

*Please provide a copy of your most recent lease agreement or mortgage statement.

Employment Information

Current Employer _____
Employer Address _____

_____

Position _____ Monthly Income _____ Duration _____

Supervisor's Name _____ Phone _____

References

PERSONAL REFERENCE 1

- Name _____
- Relationship _____
- Phone Number _____
- Email Address _____

PERSONAL REFERENCE 2

- Name _____
- Relationship _____
- Phone Number _____
- Email Address _____

Household Income Information

How many people (other than you) are living in your household? _____
number

- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____
- Name _____
  Relationship _____ Age _____

Sources of Additional Income: (check all that apply) *Please provide proof of all benefits.

Employment ☐ Monthly Amount _____

Social Security ☐ Monthly Amount _____

Child Support ☐ Monthly Amount _____

VA Benefits ☐ Monthly Amount _____

State, Town or City Welfare ☐ Monthly Amount _____

Unemployment ☐ Monthly Amount _____

Food Stamps ☐ Monthly Amount _____

Rental Assistance ☐ Monthly Amount _____

Total Monthly Income _____

Emergency Contact

- Name _____
- Relationship _____
- Phone Number _____
- Email Address _____

- Name _____
- Relationship _____
- Phone Number _____
- Email Address _____

Authorization and Signature:

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge. I authorize the New Hampshire Dental Society to retain this information on my behalf and I understand if this information has been falsified, I am liable for the full cost of services provided.

_____

APPLICANT SIGNATURE

_____

DATE