

**If more than one person in your household is applying, you MUST each submit your OWN application.
You can send separate completed applications and forms together.**

To apply for this program:

- 1) Complete and sign this application (one application per person applying)
- 2) Send copies of proof of income
- 3) Send a readable copy of your ID
- 4) For timely consideration, mail your application and proof of income no later than **December 15, 2026**, to:

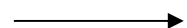
Wyoming Delta Dental Foundation
Wyoming Smiles Senior Dental Program
6705 Faith Drive
Cheyenne, WY 82009

Applications are processed in the order that they are received.

To qualify for this program, you must:

- Be a resident of Wyoming, living in Wyoming.
- Be age **65 or above**.
- Have a household income within the range shown on the income chart.
- Submit proof of income.
- Be able to travel to a Wyoming dental office in the Delta Dental Premier network for treatment.
- Must not have any current dental insurance including Medicare Advantage or be enrolled in any program providing free dental care.

First Name:	MI	Last Name:	Date of Birth:
Mailing Address:		City:	State: WY Zip:
Social Security Number:	Phone Number:	Gender:	Number of people in your household:
Email Address:	Gross Monthly Household Income:	Gross Yearly Household Income:	
Are you a veteran? ☐ Yes ☐ No			
Do you currently have dental insurance or any dental coverage, such as dental through your Medicare plan, Medicaid or are you receiving help from an organization to help you pay for your dental needs? ☐ Yes ☐ No <i>If you have or obtain a supplemental dental policy through a company like Cigna, Humana, etc., this is considered coverage and you would not be eligible for the program.</i>			
If you have other coverage, please explain what type and what is covered. <u>(If not sure, please call us!)</u> ☐ I have dental coverage through Medicare or a Medicare Advantage plan. ☐ I have dental coverage through Wyoming Medicaid. ☐ I have dental coverage through a dental insurance company. Please list the name of the company: ☐ I am receiving assistance from a local organization that is helping pay for my dental needs. Please share the name of the organization and what assistance is being provided: If you have other coverage, please explain here or attach documentation on what is covered:			



Do you currently have dentures?

- ☐ Yes, I have a Full Set of upper and lower dentures
- ☐ I only have an upper denture
- ☐ I only have a lower denture
- ☐ No, I do not have dentures

Application Agreement:

I hereby apply for coverage through the Wyoming Smiles Senior Dental program. I understand that enrollment in this program is VERY limited, and I may be placed on a waiting list. Being placed on the waiting list does not ensure I will be placed on the 2027 program.

I understand that this application will be accepted only if I meet the eligibility requirements, if there is space available in the program and if I have no other dental benefits being provided to me or any dental insurance. **If I have insurance and do not indicate that I do, I will be terminated from the program.** If accepted, I understand I will be placed in one of three programs based on my eligibility.

If accepted, I understand I will be enrolled only for the 2027 program which runs from January 1, 2027, to December 31, 2027. If I am placed on the waiting list and am then enrolled, my eligibility start date may be later than January, but my end date will remain as December 31, 2027.

I must visit a WYOMING Delta Dental Premier participating dentist. If I visit a dentist that does not participate or is outside of the state of Wyoming, I will be responsible for the cost of the visit. **I understand that this program has limited benefits and not all treatment that my dentist recommends may be covered.** If I agree to services that are not covered on my plan, I will be responsible for payment.

I hereby certify that all the information contained in this application is true and correct to the best of my knowledge.

Applicant Signature

Date

☐ Please check here if you are willing to share your dental need story to help us promote the Wyoming Smiles Senior Dental program (This is NOT required to participate in the program).

Income Chart: (Federal Poverty Level - Household income limits effective 1/1/2026)

Household Size	Gross Yearly Income	Gross Monthly Income
1	\$31,920	\$2,660
2	\$43,280	\$3,606
3	\$54,640	\$4,553
4	\$66,000	\$5,500

QUESTIONS?

CALL US AT 307-632-3313 OR 800-735-3379

Email: WYDDFoundation@deltadentalwy.org

Mail your completed application, along with your proof of income and copy of your identification to:

Wyoming Delta Dental Foundation
ATTN: WY Smiles Senior Dental Program
6705 Faith Drive, Cheyenne, WY 82009