

CONFIDENTIAL REFERRAL

YOU REQUESTED ASSISTANCE FROM

Star Dental Institute 3695 Star Ranch Road
Colorado Springs CO 80906

(719) 597 7979

Kimra Hall & Associates 410 Macon Ave

Canon City, CO 81212

(719) 276 0128

**APPLICANT INFORMATION
PLEASE PRINT**

PHONE NUMBER _____

***** PHOTO ID REQUIRED ****

NAME: _____ DOB: _____ AGE _____

STREET ADDRESS: _____ APT or LOT# _____

CITY & STATE: _____ ZIP: _____

EL PASO/FREMONT COUNTY RESIDENT _____ YEARS. US CITIZEN? YES _____ NO _____

**FILL OUT THIS REQUEST
FORM COMPLETELY**

TYPE OF AID REQUESTED _____

DO YOU OR WILL YOU RECEIVE OTHER FINANCIAL AID FOR THIS REQUEST? YES _____ NO _____

AGENCY: _____

**LIST ANY ADDITIONAL PEOPLE
WHO LIVE WITH THE APPLICANT
AS OF THE DATE OF THIS
REQUEST.**

NAME	RELATIONSHIP	AGE	MONTHLY INCOME? (Yes or No)	EMPLOYED (Yes OR No)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ATTACH ANOTHER PAGE NECESSARY.
DO NOT LIST THE APPLICANT AGAIN.

TOTAL NUMBER IN HOME _____

WORK STATUS: EMPLOYED UNEMPLOYED RETIRED DISABLED

IN THE SPACES TO THE RIGHT,
PLEASE TELL US ABOUT THE
MONTHLY INCOME AND
EXPENSES FOR YOURSELF, YOUR
SPOUSE, AND OTHER
MEMBERS IN THE HOME.
INFORMATION MUST BE
COMPLETE OR IT MAY VOID
THIS APPLICATION WITHOUT
CONSIDERATION.

**ATTACH COPIES OF
VERIFICATION OF
INCOME**

DO YOU OWN, RENT OR
ARE BUYING YOUR HOME?

RENT _____
BUYING _____
OWN _____

HOUSEHOLD MONTHLY INCOME:	APPLICANT	SPOUSE & OTHERS
WAGES AFTER TAXES		
SOCIAL SECURITY		
SSI		
SSDI		
DIB / DWB		
AND / AFDC / TANF		
FOOD STAMPS		
CHILD SUPPORT		
UNEMPLOYMENT		
WORKMEN'S COMP		
PENSIONS		
INTEREST / DIVIDENDS		
TOTAL INDIVIDUAL INCOME		
TOTAL COMBINED INCOME		

HOUSEHOLD MONTHLY EXPENSES:	MONTHLY PAYMENT
RENT / HOUSE PAYMENT	
FOOD	
MEDICINE & DOCTORS	
UTILITIES & TRASH	
CLOTHING	
PHONE & INTERNET & TV	
CAR LOAN PAYMENTS	
AUTO GAS, OIL, ETC.	
CREDIT CARD PAYMENTS	
INSURANCE (HOUSE, CAR, MEDICAL, DENTAL)	
CHILD CARE	
OTHER	
TOTAL MONTHLY EXPENSE	

DO NOT WRITE BELOW THIS LINE

FOR DENTAL OFFICE USE ONLY

Revised August 2025

DATE APPROVED: _____

PURCHASE ORDER No. _____

DOLLAR AMOUNT: _____

SERVICE PROVIDER _____

PLEASE DO NOT MODIFY OR ALTER THIS APPLICATION. USE ADDITIONAL PAGES IF NECESSARY. THANK YOU.

A. PLEASE INCLUDE AN EXPLANATION OF YOUR ECONOMIC SITUATION AND THE REASON FOR THIS REQUEST.

B. IF THIS REQUEST IS FOR DENTAL, PLEASE EXPLAIN YOUR CURRENT DENTAL NEEDS. PLEASE BE SPECIFIC SO THAT WE MAY EVALUATE YOUR REQUEST PROPERLY.

A. _____

B. _____

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IF YOU ARE USING A REFERRAL AGENCY, PLEASE PRINT NAME OF AGENCY AND HAVE THE AGENT SIGN. THANK YOU.	NAME OF AGENCY	_____	PHONE	_____
	AGENCY ADDRESS	_____	ZIP	_____
	AUTHORIZED AGENT	_____	PRINTED NAME	_____
			SIGNATURE	_____

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THE APPLICANT MUST READ THE STATEMENT TO THE RIGHT AND SIGN BELOW IT. A PARENT OR GUARDIAN MUST SIGN IF THE APPLICANT IS UNDER 18 YEARS OF AGE.

I certify that the information provided is complete to the best of my knowledge. I authorize verification and I give permission to obtain information on my case from federal, state, county, and local agencies in order to process my request for assistance. I understand that failure to answer all questions completely or failure to sign this application will result in the delay of processing this application.

APPLICANT SIGNATURE _____ **DATE** _____

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ITEMS TO SEND WITH APPLICATION

- _____ Photo ID
- _____ Verification of Income
- _____ Copy of dental treatment plan (if you have been to a dentist), or other pertinent information regarding your request.