EAST END VALLEY STREET DENTAL ASSISTANCE PROGRAM

Application & Proof of Eligibility Requirements

All East End Valley Street Neighborhood residents who want to participate in the Dental Assistance Program must meet the eligibility requirements outlined below.

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

_____ **I am aged 60 or above**

_____ **My income is below 200% of the Federal Poverty Level**

_____ **I live within the East End Valley Street Neighborhood boundaries**

_____ **I do not have dental insurance**

****Please note: Verification will be needed prior to your initial dental appointment being made.**

Signature: _____**Date:** _____

Send your application to: Mr. David Jones, Program Coordinator, EEVS Dental Assistance Program, P.O. Box 7341, Asheville, NC 28802 or EEVSDentalAssistanceProgram@gmail.com