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## SMILE BRIGHT DENTAL PROGRAM (SBDP) APPLICATION

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Disability: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

Referral Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referral Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Reason for request	Please explain in detail
Preventative Care i.e. cleaning & x-ray	
Emergency Treatment i.e. root canal, filling, & extraction	
Dentures	
Orthodontic treatment when medically necessary to correct handicapping and other malocclusions	
Gingival and periodontal diseases treatment	
Other(s), please specify:	

**Amount Requested:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

If for any reason, I do not utilize approved SBDP Services,  
 I agree to return any funding to Maryland Community Connection.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Documentation

Please attach the following documentation to the application:

- 1) Disability Supporting Documentation: Attach one of the following:  
A copy of the Individual Plan (IP), Psychological Report, or a statement verifying that the child has a developmental disability from his or her doctor.
- 2) Copy of Estimates or Invoices of dental services to be Purchased
- 3) Copy of a Maryland State issued ID card or bill noting the address

Do not write below this space

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Date Application Received: \_\_\_\_\_

Disability Documented/Verified: \_\_\_\_\_

Date of Birth Verified: \_\_\_\_\_

Approved:  Yes  No  
If no, reason: \_\_\_\_\_

Amount Approved: \$ \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Executive Director Signature: \_\_\_\_\_

Date: \_\_\_\_\_