

- New Application
- Renewal Application (Child has been on program before)

**Application Instructions:**

- ✓ Complete the application (front and back) **and sign**
- ✓ If no answer, write "None" in the box.
- ✓ Include proof of income (indicated on back of application).



**Enrollment Application**

**In Utah Mail to:**

P.O. Box 25185  
Salt Lake City, UT 84125-0185  
1 (888) 589-KIDS (5437)

**In Idaho Mail to:**

P.O. Box 2560  
Boise, ID 83701  
1 (866) 938-0084

[www.caringfoundationforchildren.org](http://www.caringfoundationforchildren.org)

**1. Tell Us Who You Are and Where You Live:**

Last Name (Parent/Guardian)	First Name	Middle Initial (Jr., Sr.)	Home Phone #	
Spouse/Domestic Partner Last Name	Spouse/Domestic Partner First Name	Middle Initial (Jr., Sr.)	Marital Status (Circle One) Married                      Single                      Domestic Partner Divorced                      Widowed                      Separated	
Home Address	City	State	Zip Code	<b>Preferred language:</b> Circle one English                      Spanish

**2. Employment Information:**

Name of Person Employed	Name of Employer	Work Phone #	How often do you get paid? Weekly, biweekly, monthly, annually	Total Gross Annual Income

Are you or your spouse/domestic partner receiving any of the following: (Circle One)  
 SSI/SSA      Workers Compensation      Unemployment      Disability      If yes, amount \$ \_\_\_\_\_ per year

Are you receiving child support? \_\_\_\_\_ If yes, \$ \_\_\_\_\_ per year

**3. Tell Us About the Children Age 17 & Younger Living in Your Household:**

Child's Last Name	Child's First Name	Your relationship to child?	Date of Birth (mo/day/year)	Age	Sex Male or Female	Social Security # (voluntary - not required)	Does this child have any other dental insurance? Yes or No	Does this child have health insurance? Yes or No	Is this child on CHIP A or B or Medicaid? If yes, please list.

**For office use only**  
Date Received \_\_\_\_\_

**For office use only**  
Eligible – Date \_\_\_\_\_  
  
Ineligible \_\_\_\_\_

**Total Family Size:** \_\_\_\_\_  
Parents plus number of dependants

**Total Gross Annual Income:** \$ \_\_\_\_\_



Please complete application on reverse side

**PLEASE SEND ONE OF THE FOLLOWING:** A copy of your two most recent pay stubs, or a copy of the first page of last year's federal income tax return, (IRS 1040, 1040A or 1040 EZ), or a copy of your W-2 Earning Statements for last year.

**COPIES MUST BE INCLUDED WITH APPLICATION IN ORDER TO BE PROCESSED.**

Income Limits (Effective 1/1/09)	
Family Size*	Gross Income Limit(s)**
2	\$29,140 or less
3	\$36,620 or less
4	\$44,100 or less
5	\$51,580 or less
6	\$59,060 or less
7	\$66,540 or less
8 ♦	\$74,020 or less
* Includes parents and children	
** Annual Maximum household income	
♦ Add \$7,480 for each additional family member over the number of 8	

**Eligibility Requirements:**

1. Child(ren) is unmarried son or daughter, stepchild, legally adopted child, or a child with a legally appointed guardian.
2. Household annual income cannot exceed income limits as indicated at right.
3. Child(ren) must be 17 years of age or younger.
4. Child(ren) resides in Utah or Idaho.
5. Child(ren) cannot be enrolled in any private or public dental plan including Medicaid or the Children's Health Insurance Program (CHIP).

**Application Agreement:**

I hereby apply for coverage through the Regence Caring Foundation for Children for my dependant child(ren) named on the reverse. I understand that this application will be accepted only if my dependant(s) meet the eligibility requirements. If accepted:

- I understand that benefits will be provided only for covered services available under the Regence Caring Foundation (annual benefit maximum \$1,000 per child per year) and that I am responsible for any services provided to my dependant(s) that are not covered by this program.
- I understand that I must notify the Regence Caring Foundation of any changes in either my own or my dependant's financial status or address, or if my dependant(s) receives any other type of dental insurance within 30 days of said change.
- **I understand that benefits will be provided for one year only.** Benefits may be terminated at any time with 30 days prior notice.
- I understand that enrollment is limited and is available on a first-come first-serve basis.
- I understand that if accepted, my child(ren) will need to reapply in one year from the enrollment date if further coverage is needed, based on medical necessity, and that he/she is limited to two years on the program.

*I authorize the release of any financial, medical or other information to the Regence Caring Foundation for Children necessary for the determination of eligibility or to pay claims for my child enrolled in the Regence Caring Foundation. I have read the above agreement and certify that the information provided on this application is correct.*

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Check here if you are willing to share your Caring Foundation story. (We occasionally get media requests for personal stories of families who have gone through the program.) This exposure will help us raise more dollars, which will allow us to provide essential care to more kids.

**BACKGROUND QUESTIONNAIRE (Parent or Guardian – Voluntary – Completion Not Required)**

The Regence Caring Foundation for Children would like to have information about its members. We may receive special grants for children with specific backgrounds and affiliations. Although we would appreciate your cooperation in providing this information, completion of this questionnaire is not required. All information is private and confidential and will not affect your child's eligibility for enrollment in the program.

1. How did you hear about the Regence Caring Foundation? \_\_\_\_\_
2. Parent's Marital Status (check one):      Divorced/Separated      Married      Single      Widowed
3. Ethnic Origin (check one):      American Indian or Alaskan Native      Asian/Pacific Islander      Black      Hispanic      White      Other
4. Religious Affiliation (check one):      Baptist      Catholic      The Church of Jesus Christ of Latter –day Saints      Episcopal  
                          Jewish      Lutheran      Methodist      Presbyterian      United Church of Christ      Other

The Regence Caring Foundation for Children is a 501 (c) (3) charitable foundation sponsored and administered by Regence BlueCross BlueShield of Utah and Regence BlueShield of Idaho, independent licensees of the Blue Cross and Blue Shield Association.