

**CLINTON COUNTY VETERANS SERVICE COMMISSION
43 S. WALNUT STREET
WILMINGTON, OHIO 45177**

Dental & Vision Assistance Application

Dental/Vision assistance promotes oral health, vision health, and overall well-being by connecting Veterans with participating local dental and vision care providers. One voucher for each service (1 for dental and 1 for vision) will be issued to an approved Veteran.

Services offered include:

- Basic annual dental examination.
- Basic dental cleaning.
- Bitewing X-rays (if recommended).
- Panoramic X-rays (if recommended).
- Fluoride treatment (if recommended).
- Basic annual vision examination.
- One set of glasses and frames.

Veterans must choose a dental or vision care provider from the provided list of participating Clinton County providers. If you miss an appointment without proper cancellation, you may be denied future dental/vision and financial assistance.

Please provide the following:

- A copy of all your DD-214(s) / DD-93(s), unless previously provided. You must have an honorable or under honorable (General) character of service, which must be visible on the DD-214 / DD-93 copy.
- Proof of Clinton County residency for at least 90 days (for example, a utility bill with your address).
- A copy of your current, valid Ohio photo identification.
- A copy of your Clinton County Veterans ID Card.
- Proof of income (tax return or current pay stubs, all other income, and VA compensation).
- Signed Liability Release Form.

INCOMPLETE APPLICATIONS WILL NOT BE APPROVED

For Internal Use Only

Service Type

☐ Dental ☐ Vision

Last date of service at CVCSC

Date of benefit review appointment

Is the Veteran eligible for additional VA benefits?

Yes or No

Are all required documents on file?

Yes or No

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DENTAL/VISION WAIVER AND RELEASE

By signing this form, I understand that I am waiving, releasing, and agreeing to hold harmless the Clinton County Veterans Service Commission from any liability arising from or related to my participation in CCVSC Dental/Vision assistance. This includes, but is not limited to, the following:

INITIAL NEXT TO EACH LINE

_____ Liability for any dental or vision procedure performed by the dental or vision care provider.

_____ Costs, fees, or other related expenses associated with my dental or vision care beyond those paid for by the CCVSC.

_____ Any fees or costs charged by the dental or vision care provider for missed appointments.

_____ Any follow-up treatments recommended by the dental or vision care provider that are not covered by CCVSC Dental/Vision assistance.

_____ Scheduling, attending, and coordinating my dental or vision care appointments with the dental or vision care provider.

By initialing the above items and signing below, I acknowledge that I have read, reviewed, and understand all of the terms of CCVSC Dental/Vision assistance. I am releasing any and all claims, either now or in the future, against the CCVSC as a participant in CCVSC Dental/Vision assistance.

Print Name

Date

Signature

Witnessed