YUKON DENTAL PROGRAM

APPLICATION

The Yukon Dental Program is a publicly funded dental plan for uninsured Yukoners. Yukoners can apply if they have a valid Yukon Health Care Insurance Plan number, no other dental coverage or benefits, and meet the income eligibility. Yukoners who are eligible for the Pharmacare and Extended Health Care Benefits program can also apply.

Clients of the Yukon Dental Program will be eligible for $600 if they are also enrolled in the Pharmacare and Extended Health Care Benefits program, or $1,300 if they have no other dental coverage or benefits. Coverage ends on June 30 each year. Applications are required annually.

Yukoners under 19 years of age can be included on the application if they are listed under the applicant's Yukon Health Care Insurance Plan, are related, and live in the same household. Family size impacts the income assessment, even if the children are not eligible for the program. Children who do not have coverage for dental services under any other program, plan or insurance group, and who are ineligible for the Children's Dental Program, can apply.

Applications and required documents can be completed online at Yukon.ca, mailed or dropped off:

In person: 4th Floor, Financial Plaza Building
204 Lambert Street, Whitehorse, Yukon

By mail: Yukon Dental Program, Insured Health Services (H-2)
Box 2703, Whitehorse, YT, Y1A 2C6

Questions?

Phone: 867-667-5209 or toll free in Yukon 1-800-661-0408, extension 5209
Email: dentalprogram@yukon.ca

Part 1: Applicant information

First name	Middle name	
Last name		Date of birth YYYY/MM/DD
Yukon Health Care Insurance Plan number	Email address	Phone number
Mailing address	City/town/village	Postal code

Do you have coverage for dental services under any other program, plan or insurance group? ☐ Yes ☐ No

If yes, are you eligible for the Pharmacare and Extended Health Care Benefits Program? ☐ Yes ☐ No

You are eligible if you are a Yukon resident and at least 65 years old or you are a Yukon resident aged between 60 and 64 and your spouse is a Yukon resident who is at least 65 years old.

Part 2: Children's information

First name	Middle name	Last name
Date of birth YYYY/MM/DD	Yukon Health Care Insurance Plan number	☐ Has other dental coverage ☐ Applying for this program
First name	Middle name	Last name
Date of birth YYYY/MM/DD	Yukon Health Care Insurance Plan number	☐ Has other dental coverage ☐ Applying for this program
First name	Middle name	Last name
Date of birth YYYY/MM/DD	Yukon Health Care Insurance Plan number	☐ Has other dental coverage ☐ Applying for this program

List additional children on a separate sheet.

Part 3: Proof of income

You must include proof of income as part of your application. We use this information to assess your income eligibility.

- ☐ I have enclosed a copy of my Notice of Assessment (issued by the Canada Revenue Agency) with this application.
- ☐ I have enclosed a letter confirming that I was a recipient of social assistance for the entire fiscal year prior to the date of application and reported no employment income.

Part 4: Declaration and consent

Initials	Declaration and/or consent
	If applicable, I confirm I am the parent or legal guardian of the above listed children and am authorized to provide consent on their behalf.
	I declare that the information provided on this application is true and correct to the best of my knowledge.
	I understand that knowingly providing false or misleading information or records is an offence and may result in the recovery of any benefits paid on my behalf.
	I understand that the Yukon Dental Program will use the information provided on this application and on my Notice of Assessment to determine my eligibility for dental services, as well as to evaluate the program.
	For the purpose of verifying program eligibility, and if I am deemed eligible, I authorize the Yukon Dental Program to collect, use and disclose my information, when reasonably necessary for program eligibility, enrollment, coverage and administration with: • other Insured Health Services programs (for example, the Pharmacare and Extended Health Care Benefits program); • Pacific Blue Cross, the benefits carrier; and • the dental service provider.
	I agree to notify the Yukon Dental Program of any changes to my household, insurance coverage, or any other factor that may affect my eligibility for coverage within 30 days of the change coming into effect.
	I understand that I may withdraw my consent from the Yukon Dental Program to collect, use and disclose my information by providing written notice and that my right to withdraw consent may be subject to potential implications. I may contact the Yukon Dental Program at 867-667-5209 for further information about how to withdraw consent, and the implications of withdrawing consent.

Part 5: signature

Applicant name (print)	Applicant signature	Date (YYYY/MM/DD)
Substitute decision-maker or guardian name (print)	Substitute decision-maker or guardian signature	Date (YYYY/MM/DD)

Office use only		
Date received YYYY/MM/DD	Reviewed by	Added to application log

Information contained in this form is collected, used and disclosed in accordance with Yukon's *Health Information Privacy and Management Act* and other applicable laws. A written statement of Health and Social Services information practices can be viewed at https://yukon.ca/healthprivacy or by contacting the department's privacy officer at healthprivacy@yukon.ca.

Part 6: Demographic and dental care information (optional)

The following questions are **optional**. Your answers help to ensure that the Yukon Dental Program is meeting the needs of all Yukoners and provides the program with information on the dental health of applicants. All responses are kept confidential and are only used for statistical analysis and program evaluation.

Do you identify with any of these groups and communities? Please check all that apply.

- ☐ First Nations, Inuk/Inuit and/or Métis
- ☐ Newcomer to Canada
- ☐ Racialized person or person of colour
- ☐ Person with a disability
- ☐ Person with mental wellness or substance use concerns
- ☐ LGBTQ2S+
- ☐ I do not identify with any of these groups
- ☐ Prefer not to answer

What gender do you currently most identify with?

- ☐ Woman
- ☐ Transgender Woman
- ☐ Man
- ☐ Transgender Man
- ☐ Non-binary
- ☐ Unsure/unknown
- ☐ Gender not listed. I identify as: _____
- ☐ Prefer not to answer

What is the highest level of education you have completed?

- ☐ No formal schooling
- ☐ Elementary school
- ☐ High school
- ☐ Post-secondary certificate, trade, or apprenticeship
- ☐ College diploma
- ☐ University undergraduate degree (e.g. BA, BSc)
- ☐ University graduate degree (e.g. MA, MSc, PhD)
- ☐ Prefer not to answer

How often do you brush your teeth?

☐ More than once a day ☐ Once a day ☐ A least once a week but not daily ☐ Less than once a week ☐ Never

How often do you floss your teeth?

☐ More than once a day ☐ Once a day ☐ A least once a week but not daily ☐ Less than once a week ☐ Never

How would you describe the state of your teeth?

☐ Excellent ☐ Very good ☐ Good ☐ Average ☐ Not good ☐ Bad ☐ Not sure

How would you describe the state of your gums?

☐ Excellent ☐ Very good ☐ Good ☐ Average ☐ Not good ☐ Bad ☐ Not sure

How long has it been since you last saw a dentist or a dental therapist?

☐ Less than 6 months ☐ Between 6 and 12 months ago ☐ More than 1 year but less than 2 years ☐ Between 2 to 5 years ☐ 5 years or more ☐ Never received dental care

What was the reason for your last visit to the dentist? Please check all that apply.

- ☐ Routine check-up/treatment
- ☐ Preventative treatment (e.g. cleaning, fluoride, scaling)
- ☐ Consultation/advice
- ☐ Non-traumatic dental emergency treatment (e.g. tooth decay, abscesses, gingivitis, periodontitis)
- ☐ Traumatic dental emergency (e.g. injury to face resulting in tooth damage or loss)
- ☐ Pain or trouble with teeth, gums and/or mouth
- ☐ Treatment follow-up
- ☐ Don’t know or can’t remember

Part 6: Demographic and dental care information (optional)

In the past 12 months, have you experienced any problems because of the state of your teeth, gums or mouth? Please check all that apply.

- ☐ Difficulty eating
- ☐ Difficulty with speech/pronouncing words
- ☐ Having to take time off work
- ☐ Interrupted sleep
- ☐ Reduced social interactions
- ☐ Feeling anxious
- ☐ Other (please specify): _____
- ☐ None of the above

In the past 12 months, what barriers have you experienced when trying to get dental care for yourself? Check all that apply.

- ☐ I can't afford dental care
- ☐ Dental services are not available in my area
- ☐ The waitlist was too long
- ☐ I felt anxious or uncomfortable about receiving dental care
- ☐ I felt that dental services were inadequate
- ☐ Had trouble getting or paying for childcare
- ☐ Had trouble getting or paying for transportation
- ☐ I haven't experienced any barriers
- ☐ Not applicable (no dental care was needed)
- ☐ Other (please specify): _____

If you had needed to go to the dentist in the past year, how would you have paid for it?

- ☐ Social assistance funding
- ☐ Benefits through an employer
- ☐ Not paying other bills/expenses (e.g. not paying rent that month)
- ☐ A free dental service day
- ☐ Using my savings
- ☐ I could not have afforded to go to the dentist
- ☐ Other (please specify): _____

Are you able to regularly afford dental supplies (toothpaste, floss, toothbrushes)?

☐ Yes ☐ No ☐ Unsure

Do you currently need dental services? Please check all that apply.

- ☐ Diagnostic and preventative services (e.g. check-up, teeth cleaning, fluoride treatment)
- ☐ Restorative treatments (e.g. cavity fillings, crown or bridges)
- ☐ Extractions (removal of teeth)
- ☐ Prosthetics (e.g. dentures, including repair and maintenance)
- ☐ Periodontal (gum) treatments
- ☐ Orthodontics (e.g. braces)
- ☐ I don't think any dental services are needed
- ☐ Not sure
- ☐ Other (please specify): _____

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