YUKON DENTAL PROGRAM

APPLICATION

Use this service to apply for dental coverage or benefits if you aren't currently covered by any other private or employer-based dental plan. If you are partially covered by the Pharmacare and Extended Health Care Benefits program, you can apply for additional coverage. This form must be completed annually.

Before you start

You will need:

- your Yukon Health Care Insurance Plan (YHCIP) number;
- the YHCIP numbers of any children or dependents;
- a copy of your Notice of Assessment from the Canada Revenue Agency;
- an email address or phone number in case we need to contact you.

Submit your application

- **In person:** We are located on the 4th Floor of the Financial Plaza Building at 204 Lambert Street in Whitehorse. Our office is open Monday to Friday from 8:30 am to 4:30 pm. We are closed on statutory holidays.
- **By mail:**
  Government of Yukon
  Department of Health and Social Services
  Yukon Dental Program, Insured Health Services (H-2)
  Box 2703
  Whitehorse, Yukon Y1A 2C6
- **Online:** Applications and required documents can be completed online at Yukon.ca.

For questions about applying for the Yukon Dental Program email dentalprogram@yukon.ca or phone 867-667-5006, toll free in the Yukon 1-800-661-0408, extension 5209.

Part 1: Personal information		
First name	Middle name	Last name
Date of birth YYYY-MM-DD	Yukon Health Care Insurance Plan number	
Phone number	Email address	
Mailing address		
Unit number (optional)	Street address or P.O. box number	
City, town or village	Province or territory	Postal code

How do I know if I have coverage for dental services under any other program, plan or insurance group?

Other coverage could include a plan provided through the Non-Insured Health Benefits Program or the Children's Dental Program for instance.

How do I know if I'm eligible for the Pharmacare and extended health care benefits?

You are eligible if you are:

- a Yukon resident **and** at least 65 years old; OR
- a Yukon resident aged between 60 and 64 **and** your spouse is a Yukon resident who is at least 65 years old **and** eligible for Pharmacare.

Do you have coverage for dental services under any other program, plan or insurance group?

Check all that apply to you.

☐ Canada Dental Care Plan

☐ Pharmacare and Extended Health Care Benefits Program

☐ Private or employer-based insurance

☐ Other (specify): ____________________

☐ None of the above

Part 2: Children's information

Include all children, under 19 years of age who are listed as a dependant on your YHCIP file, even if they are covered by other programs. If you're unsure whether your children are listed on your YHCIP file, call Insured Health at 867-667-5006.

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

We require a copy of your most recent Notice of Assessment (issued by the Canada Revenue Agency). We need line 15000 and your address on your Notice of Assessment to determine eligibility for the program.

We will accept a scan or a photo of the document.

☐ I have attached my proof of 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 867-667-5006 for further information about how to withdraw consent, and the implications of withdrawing consent.

Part 5: Signature

Applicant name (print)	Applicant signature	Date
Substitute decision-maker or guardian name (print)	Substitute decision-maker or guardian signature	Date

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? 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 ☐ Good ☐ Average ☐ Not good ☐ Bad ☐ Not sure

How would you describe the state of your gums?

☐ Excellent ☐ 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
- ☐ I have never received dental care

What was the reason for your last visit to the dentist? 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

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

☐ Yes ☐ No ☐ Unsure

Part 6: Demographic and dental care information (optional)

In the past 12 months, if you needed to go to the dentist, 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
- ☐ Other (specify): ____________________
- ☐ I could not have afforded to go to the dentist

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
- ☐ Other (specify): ____________________
- ☐ Not applicable (no dental care was needed)

In the past 12 months, have you experienced any problems because of the state of your teeth, gums or mouth? 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 (specify): ____________________
- ☐ None of the above

Do you currently need dental services? 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
- ☐ Other (specify): ____________________
- ☐ Not sure