Bellefonte Borough Authority
236 West Lamb Street, Bellefonte, PA 16823

FLUORIDE SUPPLEMENT PROGRAM

This is a FREE Fluoride Supplement Program offered to Bellefonte Water System customers, who otherwise would not have the means to receive fluoride supplements. This program is being offered by the Bellefonte Borough Authority as a community service. The Bellefonte Borough Authority, for system customers who do not have any other means to pay for fluoride supplementation, will provide a fluoride supplement prescription reimbursement program. For any questions, please call the Bellefonte Borough Offices at 814-355-1501.

Who Should Participate in the Supplement Program?

- Children 6 months to 16 years
- Children who are not covered by any other insurance or medical assistance program

Program Requirements. You Must:

- Be a resident and customer of the Bellefonte Borough Authority – **Bellefonte Distribution system.**
- You must be between the ages of 6 months and 16 years. Parents shall submit documentation.
- Parents or guardians need to submit a completed application.
- Have an appointment with a dentist or physician to get a prescription for your fluoride drops or tablets.
- Have no other insurance coverage or medical assistance available to you. Reimbursement of insurance co-pays is not eligible under this program. Appropriate documentation will be required.
- Pay out-of-pocket and submit your pharmacy receipt and related documents.

Name of Child: ______________________________

Address of Child: ____

Child's Date of Birth: __________________________

Name of Parent or Guardian: ___________________________________

Address: ____

Phone: _______________________

Date of Child's Most Recent Dental/Physician Appointment: ______________________

Name of Dentist/Dental Office or Physician/Physician's Office: _________________________

Phone Number: _________________________

I, _____________________________, have examined __________________, and it is my opinion that the child should participate in the Bellefonte Borough Authority Fluoride Supplement program.

____
Signature of Dental Professional/Physician

Is your child currently covered by any kind of medical insurance or medical assistance through an employer, spouse, or governmental program?

If so, what coverage is available?

Company or Program Name:____
Address:____
Contact Person:____
Phone:____

If not, I understand that if my child does participate in the fluoride supplement program that:

- ✓ the recommended amount of fluoride supplement should not be exceeded.
- ✓ fluoride drops or tablets must be kept out of the reach of children.
- ✓ this program is voluntary.
- ✓ the program reimburses only the cost of fluoride supplementation after appropriate documentation is submitted.
- ✓ I will give notice to the Bellefonte Borough Authority as soon as any type of insurance coverage becomes available for my child

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Signature of Authorized Person Date