Department of Health and Social Care

Rheynn Slaynt as Kiarail y Theay

Primary Care Services
Department of Health and Social Care
Crookall House
Demesne Road
Douglas
IM1 3QA

Tel no: (01624) 642694
Website: www.gov.im/dhsc

Dear Sir/Madam

In accordance with Regulations made under the National Health Service Act, the Department of Health and Social Care has discretionary powers to provide the maximum assistance available in respect of Ophthalmic/Dental Services, for those persons who do not automatically qualify but for whom the cost of treatment would be a financial hardship.

Persons automatically entitled to maximum assistance towards **Dental Treatment** include those in receipt of Income Support, Employed Persons Allowance, Income Based Jobseekers Allowance, a War Disablement Pensioner or Registered Blind.

Persons automatically entitled to a Voucher towards the cost of **glasses** include those in receipt of Income Support, a War Disablement Pensioner or Registered Blind.

If you do not qualify by being in receipt of a benefit as detailed and you consider that the circumstances of your case are such as to entitle you to maximum assistance on low income grounds, you are invited to complete the form of application overleaf. Please bring or send it to this Office as soon as possible.

The information you are asked to give will be used only for the purpose of determining your entitlement, and will be restricted to the officers dealing with your case.

Yours faithfully

PRIMARY CARE SERVICES

Form F1

Please complete in CAPITAL LETTERS

FULL NAME ____ Married/Widowed/Single/ Separated/Divorced/Civil Partnership

ADDRESS

____

______________________________________ POSTCODE_________________________

DATE OF BIRTH ________________________ OCCUPATION ________________________

TELEPHONE NUMBER __________________

DELETE AS APPLICABLE NATURE OF TREATMENT - OPTICAL/DENTAL

OWNER OCCUPIER/TENANT
AMOUNT OF RENT/MORTGAGE/LODGINGS £ __________________________ per week

DEPENDANTS – WIFE/HUSBAND/PARTNER
Number of children under 16 __________ State ages ____________________

Income from all sources – **Per Week**
(Including income of your wife/husband/partner)
Please describe the source of each item of income eg Pension, Benefits

____ £ ____________________

____ £ ____________________

____ £ ____________________

____ £ ____________________

TOTAL £ _______________________

Please describe the source of each item of income, eg Pension, Benefits, wages etc

(If you are a student in full time education, please list your annual income from all sources – including wages from any seasonal work undertaken)

TOTAL £ _______________________

Please give brief details of any bank accounts or other capital resources held by yourself and your wife/husband/partner/civil partner

____ £ ____________________

Any other information which you may think may have a bearing on your case.

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I declare that to the best of my knowledge and belief that the above statements are true and correct and herby claim exemption from the payment of the authorised changes in respect of my treatment. I consent for Primary Care Services to contact the Department of Social Security to confirm which benefit I am in receipt of. ☐ Yes ☐ No
NB A false statement made with the fraudulent intent by the applicant may lead to legal proceedings.

SIGNATURE ____ DATE ___________________

FOR OFFICE USE
APPLICATION
DENTAL – APPROVED/NOT APPROVED SIGNED _________________________ DATED____________
OPTICAL – APPROVED/NOT APPROVED SIGNED ________________________ DATED_____________