

# Department of Health and Social Care

*Rheynn Slaynt as Kiarail y Theay*

## Family Practitioners

Crookall House

Demesne Road

Douglas, Isle of Man

IM1 3QA

Telephone (01624) 642612

Fax (01624) 686707

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Dear Sir/Madam,

In accordance with Regulations made under the National Health Service Act, the Department of Health and Social Security 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,

**FAMILY PRACTITIONER SERVICES.**

Form F.1.



**Please complete in CAPITAL LETTERS**

FULL NAME \_\_\_\_\_ Married / Widowed / Single  
Separated / Divorced / Civil Partnership  
ADDRESS \_\_\_\_\_  
\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
TELEPHONE NUMBER \_\_\_\_\_

**DELETE AS APPLICABLE**                      NATURE OF TREATMENT - OPTICAL / DENTAL

OWNER OCCUPIER / TENANT  
AMOUNT OF RENT / MORTGAGE / LODGINGS        £ \_\_\_\_\_

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 e.g Pension, Benefit**

_____	£ _____	Please describe the source of each item of income, eg Pension, Benefit, wages etc
_____	£ _____	
_____	£ _____	
_____	£ _____	
<b>TOTAL</b> £ _____		

(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.

\_\_\_\_\_  
\_\_\_\_\_

I declare that to the best of my knowledge and belief that the above statements are true and correct and hereby claim exemption from the payment of the authorised charges in respect of my treatment. NB A false statement made with the fraudulent intent by the applicant may lead to legal proceedings.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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FOR OFFICE USE  
APPLICATION

DENTAL - APPROVED / NOT APPROVED SIGNED \_\_\_\_\_ DATED \_\_\_\_\_  
OPTICAL – APPROVED/NOT APPROVED SIGNED \_\_\_\_\_ DATED \_\_\_\_\_