Sliding Fee Scale - Income Worksheet

Do you receive Medical Assistance? ❒ Yes ❒ No If Yes, Medical Insurance Carrier:___________________ Policy #________________________

Do you have Dental Insurance? ❒ Yes ❒ No If Yes, Dental Insurance Carrier: _______________________ Policy #_________________________

<u>A minimum deposit of $100 will be charged for the initial appointment.</u> The remaining charges for services provided may be discounted based on your income and household size. Full payment is requested at the time of each visit.

Head of Household

<table>
<tr><td colspan="5">Name</td></tr>
<tr><td colspan="3">Address   City</td><td>State</td><td>Zip Code</td></tr>
<tr><td>Home Phone</td><td>Work Phone</td><td>Occupation</td><td colspan="2">Name of Employer</td></tr>
<tr><td>Date of Birth</td><td>Sex
❒ Male ❒ Female</td><td>Marital Status
❒ Single ❒ Married ❒ Divorced</td><td colspan="2">Social Security Number</td></tr>
</table>

Please complete the following information for <u>all members of the household</u>. Be as accurate as possible. You will be required to provide proof of your income. (Income taxes, paystubs, social security benefits statement, unemployment benefits statement, letter from your employer, etc.) if you choose not to provide the financial information, you will be required to pay the full cost of services provided. Income will be verified on a yearly basis.

Name	Relationship	Age	Date of Birth	Monthly Income	Employer

Are any household workers considered seasonal? ❒ Yes ❒ No If yes, Type of work: ________________________________

List amount received per month from other sources of income:

- ❒ Allowance
- ❒ Dividends/Interest
- ❒ Income from Property
- ❒ Public Assistance
- ❒ Retirement/Pensions
- ❒ Self-Employment
- ❒ Social Security
- ❒ Tips
- ❒ Unemployment
- ❒ Veteran's Benefits
- ❒ Workers Compensation
- ❒ Other: __________________________

Total other income: _______________________

AUTHORIZATION AND ASSIGNMENT

The preceding information is true to the best of my knowledge. I request the Bridging the Dental Gap Clinic to provide my family and I with dental care. I acknowledge my responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for dental services to be paid to Bridging the Dental Gap. I understand that failure to pay the balance of the outstanding fees owed to Bridging the Dental Gap within 90 days will result in my account being turned over to a collection agency.

Signed **X** ____ Date: ______________________

FOR CLINIC USE ONLY

Sliding fee Discount %	Date	Documents Used	Staff initials

Revised February 2021