SARRELL REGIONAL DENTAL CENTER FOR PUBLIC HEALTH, INC.
ENTERPRISE OFFICE

DISCOUNTED/SLIDING FEE APPLICATION

Office Policy

It is the policy of **Sarrell Regional Dental Center for Public Health, Inc. - Enterprise Office**, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services, which are received from another **Sarrell Regional Dental Center for Public Health, Inc. office** or other outside facilities, including reference laboratory orders and other such orders. In the hope that your financial situation improves, discounts apply to current, not future services. Please inquire at the front desk if you have questions.

Total Household Income

➪ **Number of related persons living in your household:______**

➪ **Please complete ONE of the columns below to establish your *Total Household Income.***

Household Member	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependents under age 18			
Total			

Note: *Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans payments, new business or self employment, alimony, child support, military, unemployment and public aid.*

➪ ***I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.***

✘________________________________ ✘________________________________ Date:___/___/___

Name (Print) ***Signature***

Office Use Only

Patient Name:________________________________ Discount:________________________

Date of Service:______________________________ Approved by:_____________________

Revised 7/28/2010

STAFF INITIALS ____________

SARRELL REGIONAL DENTAL CENTER FOR PUBLIC HEALTH, INC. – ENTERPRISE OFFICE

Dental Assistance Plan Application

Household Information

Name of Head of Household:____________________________

Street:____________________________

City:____________________________

Relation to Patient: ____________________________

Health Insurance Provider:____________________________

Place of Employment:____________________________

State:______________Zip:______________

Phone:____________________________

Social Security Number:____________________________

Dependent Information

➪ ***Please list spouse and dependents under age 18***

Patient Name:____________________________

▸*Date of Birth*:____/____/____

Spouse:____________________________

▸*Date of Birth*: ____/____/____

Dependent:____________________________

▸*Date of Birth*: ____/____/____

Dependent:____________________________

▸*Date of Birth*: ____/____/____

Dependent:____________________________

▸*Date of Birth*: ____/____/____

Dependent:____________________________

▸*Date of Birth*: ____/____/____

Dependent:____________________________

▸*Date of Birth*: ____/____/____

Dependent:____________________________

▸*Date of Birth*: ____/____/____

Annual Household Income

Source	Self +	Spouse +	Other =	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity & veterans benefits				
Alimony, child support, military family allotments				
Income from business self employment and dependents				
Rent, interest, dividend & other income				
Total Income				

Verification Checklist

➪ ***Please provide copies of <u>one of each</u> of the listed items.***

	YES	NO
▸ Identification/Address: Driver's License, birth certificate, employment ID, social security or other	❍	❍
▸ Income:Prior year tax return, three most recent pay stubs, or other	❍	❍
▸ Insurance: Insurance card(s)	❍	❍
▸ Medicaid: Application made or evidence of rejection	❍	❍

I certify that the above information shown above is correct and understand verification is required for approval.

✘____________________________ ✘____________________________Date:____/____/____

Name (Print) ***Signature***

Office Use Only

Pay Class Approved:____________________________Effective Date:____________________________

Approved by:____________________________Expiration Date:____________________________

STAFF INITIALS________________