Children's Dental Health Services

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# Sliding Fee Scale Application

| Personal Information | | | Today's Date: / / | |
|---|---|---|---|---|
| First Name: | Middle: | Last: | Other names: | |
| Home Address: | | City: | State: | Zip: |
| Mailing Address: | | City: | State: | Zip: |
| Home Phone #: | | Cell Phone #: | | |
| Date of Birth: | Social Security # | | Do you have insurance? Yes ☐ | No ☐ |
| Marital Status: | Single ☐ | In a relationship ☐ | Married ☐ Divorced ☐ | Separated ☐ Widowed ☐ |

| Household Size | | |
|---|---|---|
| **Name** | **Date of Birth** | **Social Security Number** |
| | | |
| | | |
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| | | |

NOTE: To comply with federal regulations, in order to give you a discount on our dental services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Proof of income is required. Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

## Household Income

| Name | Amount | Frequency | Employer: |
|---|---|---|---|
| You | $ | Monthly | |
| Spouse | $ | Monthly | |
| Children | $ | Monthly | |
| Other | $ | Monthly | |
| **TOTAL** | $ | Monthly | |

| Other Income | You | Spouse | Other | Children | Subtotal |
|---|---|---|---|---|---|
| Social Security | | | | | |
| Public Assistance | | | | | |
| Retirement Pension | | | | | |
| Food Stamps | | | | | |
| Child Support, Alimony | | | | | |
| Interest Income | | | | | |
| Other | | | | | |

Sliding Fee Scale:

A – 80% Discount

B – 60% Discount

C – 40% Discount

D – 20% Discount

E – 0% Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Children's Dental Health Services if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Children's Dental Health Services. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Signature:_____

Name (Print):_____

**SUBMIT**