SARANAC LAKE VOLUNTARY HEALTH ASSOCIATION, INC.
75 MAIN STREET, SUITE 2
SARANAC LAKE, NY 12983
518-891-0910

Request for Dental Assistance

Name of Patient: ______________________ Date of Birth: ______________
Name of Applicant if Patient is a Minor: ______________________
Present Address: ______________________
Mailing Address (if different): ______________________
Home Telephone No.: ____________ Work Telephone No.: ____________ Cell Telephone No.: ____________
School District of Residence: ______________________Referred by: ______________

Does Patient Receive Medicaid Assistance, Family Health Plus or have Dental Insurance Coverage? ☐ Yes ☐ No
If Yes, What Is Your Coverage?

____

Total Number of People Living in Patient's Household _________

Monthly Total Gross Income of All Household Members:		**Monthly Expenses and Disbursements:**	
Wages and Salaries	$____________	Rent/Mortgage payment	$____________
Interest and Dividends	$____________	Real Estate Taxes	$____________
Pension Income, Rental Income, Unemployment, Workers' Compensation	$____________	Utilities, Insurances	$____________
		Loans, Credit Cards	$____________
Child Support, Alimony/Maintenance	$____________	Child Support, Alimony, Maintenance, etc.	$____________
Other Income Including Food Stamps, Social Service Benefits, Social Security, Disability, etc.	$____________	Food	$____________
Other Income **(please explain below)**	$____________	Other **(please explain below)**	$____________
Total Monthly Gross Income	**$**____________	**Total Monthly Expenses**	**$**____________

Please include 2 most current, different paystubs for <u>each</u> person employed and/or other income verification documents

Income Explanation/Comments: ______________________
____
____

Expense and Disbursements Explanation/Comments: ______________________
____
____

Is There a Specific Reason You Need to See a Dentist? **(please explain)** ______________________
____
____

Name of Dentist______________________

Total Cost of Procedure	$____________
Contribution by Dentist	- $____________
Adjusted Total Cost of Procedure	$____________
Contribution by Patient	- $____________
Amount Requested from SLVHA	**$**____________

Comments by Patient (if any): ______________________
____
____

I affirm that the above statements are true and accurate. I consent that the patient dental records can be released to SLVHA if requested.

______________________ __________
Patient Signature (parent or guardian if patient is a minor) Date

FOR OFFICE USE ONLY

Notes: **SEE BACK --→**

Approved $ ____________

by: ______________________ __________
DECAF Member/Board Member Date

by: ______________________ __________
DECAF Member/Board Member Date

Denied by: ______________________ __________
DECAF Member/Board Member Date

Denied by: ______________________ __________
DECAF Member/Board Member Date

Reason for Denial:
____
____
____

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NOTES: ____