SARANAC LAKE VOLUNTARY HEALTH ASSOCIATION, INC.
81 MAIN STREET, SUITE 3
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: _____