Community Health Center - ***DENTAL***

ANNUAL REQUEST FOR ELIGIBILITY FOR SLIDING FEE SCALE DISCOUNT PROGRAM

As provided for by Federal Law, I hereby request that the **Community Health Center** make a written determination of my eligibility for a Sliding Fee Scale for services rendered at the **Community Health Center**. I understand the information which I submit concerning my annual income and family size is subject to verification by the **Community Health Center** and authorize all necessary means to verify the information provided by me. I also understand that if the information which I submit is determined to be false, such determination will result in denial of approval for participation in the Sliding Fee Scale Discount program and I will be liable for the full charges of the services rendered to me. I authorize you to release any information acquired in the course of my examination or treatment to the Department of Medical Security or its designee.

The information requested will be held in the strictest of confidence and will be used solely for the purpose of determining Sliding Fee Scale Discount Program eligibility.

Name ____________________ Date of Birth ____________________

Address ____________________ Telephone ____________________

PLEASE LIST BELOW ALL HOUSEHOLD MEMBERS (See attached)

FIRST/LAST NAME	RELATIONSHIP	DATE OF BIRTH	PATIENT *(CIRCLE ONE)*	INSURED *(CIRCLE ONE)*
1.			YES / NO	YES / NO
2.			YES / NO	YES / NO
3.			YES / NO	YES / NO
4.			YES / NO	YES / NO
5.			YES / NO	YES / NO
6.			YES / NO	YES / NO

(Please add more lines as necessary)

FEDERAL INCOME VERIFICATION FOR THE HOUSEHOLD MUST BE SUBMITTED IN ORDER TO PROCESS THIS APPLICATION (e.g. Tax Return, SS, Disability, Unemployment documents. NO Pay Stubs or W2s)

. MISSING INFORMATION AND/OR DOCUMENTATION WILL RESULT IN A DELAY IN PROCESSING.

PATIENT (OR GUARDIAN) ____________________ DATE OF BIRTH ____________________ SOCIAL SECURITY ____________________

HEAD OF HOUSEHOLD ____________________ DATE OF BIRTH ____________________ SOCIAL SECURITY ____________________

RELATIONSHIP ____________________ SIGNATURE ____________________ DATE ____________________

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SOURCES OF MONTHLY INCOME **MONTHLY AMOUNT**

(Complete all that apply)

Full-time, **P**art-time or **S**elf-employed (Circle below)

______________________________ Company Name – Current Job 1	F	P	S	$__________________
______________________________ Company Name – Current Job 2	F	P	S	$__________________
Unemployment Compensation				$__________________
Workman's Compensation				$__________________
Social Security Benefits				$__________________
Retirement or Disability				$__________________
Alimony or Child Support				$__________________
Welfare or Other State Aid				
Other Income (specify)________________________				$__________________
TOTAL MONTHLY INCOME				**$**__________________

Per Waiver of Fees Application (Hardship determined)

Insurance Type/ confirm date:—____

Other information: ________________________________

Adjusted Income____________Family Size________________SFS% ________________________

SLIDING FEE SCALE ELIGIBILITY DETERMINATION

(CIRCLE) YES /NO

Services seeking: (CIRCLE) Medical Dental Eyecare Behavioral Health Pharmacy Other (specify)

CHCCC REVIEWER (STAFF) NAME:____

APPROVAL DATE:____

Eligibility for the program is for a one year period. A new application will be required a year from approval date.