SLIDING FEE SCALE DISCOUNT ENROLLMENT FORM

The Caring Hands Dental Clinic may be able to offer dental services at a reduced rate based on the total number of members in the household, not enrolled in a Mn Health Care Program or other dental insurance program, and the combined income of all household members, related or not. To determine the possibility of eligibility in this reduced rate program, all appropriate documentation of income and household size is required, see procedure form. If proof of income is not verifiable or provided, as well as household size, insurances and any other requirements, the applicant(s) will not be able to participate in this program and may be referred to other options.

APPLICANT(s) INFORMATION

Last name ______________________________First name ___________________________MI__

Last name ______________________________First name ___________________________MI__

Address ____

City ____________________________County _________________________ZIP ____________

Best daytime phone #s ____

for office use only

Total in household _______
Annual gross income of all members $ ______________
Qualified for Fee Scale?
YES / NO

By: ___________________

List ALL the people in your household; include yourself, spouse, children and ALL others, related or not;

Last name	First name	MI	date of birth	social security #	relationship

Total gross household asset value, includes vehicles, house, properties, recreation equipment, stocks, etc. $______________________

Do you or any household member have any Minnesota Health Care Program insurance, such as Medical Assistance or MinnesotaCare? YES/NO Does anyone in the household have private dental insurance? YES/NO
Have you applied for MA or MnCare and been denied? YES/NO, if yes, provide copy of recent denial letter.
My Signature below certifies that under penalty of perjury that all declarations made in this eligibility request are true, accurate and complete. If there are any changes to income or household size, or other pertinent information, I will contact the Clinic Director immediately. By signing below I also agree to be responsible for any and all payments due at the time of service.
The cost of the initial dental exam will be discussed when the appointment is made. At the time of your appointment, a plan of treatment will be developed for the services needed that will show you what it will cost. Payment methods will also be discussed.

SIGN____DATE____________________________________

SIGN____DATE____________________________________

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