## Mountain Health Center / Mountain Health Dental Care

### Application for Sliding Fee Discount Program

**Applicant** Today's Date _____

Name (Last) _____ (First) _____ (MI) _____

Street Address _____

City _____ State _____ Zip _____

Do you live in Addison County? Yes _____ No _____

Home Phone _____ Cell Phone _____

SS# _____ DOB _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

It is the policy of MHC/MHDC to provide essential medical and dental services to our patients. Discounts are offered based upon household size and annual income. Please complete the following information and return the application with proof of all income sources. **Household includes the income of everyone who lives in the household, regardless of relationship.**

The discount will apply to all services received at this clinic, but not those services which are purchased from outside such as some lab tests, cosmetic dentistry, certain dental procedures, and pharmacy items.

Number of persons living in your household: ☐

| Household Member | Relationship to Applicant | DOB | Income per individual (Please specify annual, monthly, bi-weekly) * |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | TOTAL | |

*** Please include income from ALL sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, self-employment (requires a copy of last year's taxes), alimony, child support, military, unemployment, and public assistance.**

(Please see other side)

| **VERIFICATION CHECKLIST (Attach copies)** | **YES** | **N/A** |
|---|---|---|
| Identification with address for applicant: Driver's License/Electric bill/etc. | | |
| Income: most recent **2** pay stubs | | |
| Self Employed: Last year's tax return | | |
| Social Security: Bank statement | | |
| Child Support/Alimony | | |
| Other Income | | |

If you feel that the information you provided above does not accurately reflect your current financial situation, please add any comments that may help us understand your need for assistance below.

I understand that, to the best of my knowledge, that all of the preceding answers are true and correct. I understand that if I have any change in my income in the next twelve months, I will notify the Mountain Health Center/Mountain Health Dental Care. Copies of tax returns, pay stubs, and other information verifying income is attached to this application.

**I acknowledge that I am financially responsible for any unpaid balance.**

Print Name: _____

Signature: _____

Date: _____

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FOR CENTER USE ONLY

Auth. Initials_____ Slide Level _____ Approval/Denial Date _____ Renewal Date _____

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