

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.

In order to process your application for sliding fee scale, we need proof of your current address and your financial status. Please see the verification checklist below.

VERIFICATION CHECKLIST FOR THE HOUSEHOLD (Attach copies)	YES	N/A
Identification with current address for applicant: Driver's License/Electric bill/etc.		
Income: most recent 2 pay stubs		
If Self Employed, provide last year's tax return		
If receiving Social Security, provide the most recent copy of the letter		
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: _____

FOR CENTER USE ONLY

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