Community
Smiles Dental

Patient/Family Application for Sliding Fee Discount

It is the policy of Community Smiles Dental to provide essential services regardless of the patient's ability to pay. Community Smiles Dental offers discounts based on family size and annual income.

The discount will apply to all services received at Community Smiles Dental. You must complete this form every 12 months or if your financial situation changes.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

Name of Head of Household: _____
Address: _____
City: _____ State: _____ Zip code: _____
Place of Employment: _____

Please list spouses and dependents under age 18.

	Name		Name
Self		**Dependent**	
Spouse		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	

Source	Self	Spouse	Total
Gross wages, salaries, and tips			
Income from business or self-employment			
Income from unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement			

Income from interest, dividends, rents, royalties, estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources			
Total Income			

NOTE: Copies of tax returns, pay stubs, or other information verifying will be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name(Print): _____

Signature: _____

Date: _____

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Patient Name: _____
Total Income/Family Size: _____
Approved Discount/% of FPL : _____
Approved by: _____
Date Approved: _____Valid Through Date(1 year from approved date): _____

Calculation: (average out check stubs and multiple by frequency)

Verification Checklist	**YES**	**NO**
Identification: Driver's license, ID, or Passport		
Income: Prior year tax return, Two most recent pay stubs, or other		