Caring Hands Dental Clinic
West Central Dental Resources, Inc.
A Community Dental Access Clinic

SLIDING FEE SCALE REQUIREMENTS

No application will be reviewed without the required documentation.

- Documentation of *ALL* current household income for *EVERY* household member, related or not, residing in the home; ***required*** income verification documents:
  - The most recent 4 paycheck/income, stubs/receipts/statements **and** individual or joint federal income tax statement from previous year, just first page showing gross income.

- In addition to any of the following if applicable:
  - Social Security statement showing ***gross*** amount received ***currently***.
  - College award letter with total amount of grants or loans received.
  - Any other form of income from investments, retirement benefits, etc.

*NOTE: Maximum combined household gross assets of $200,000. The total household number to determine the fee level excludes any household member served by MA/MNCare or other dental insurance, but any income from those insured members will be counted towards the total income.

- A denial letter showing that you have been recently denied for MA/MNCare.
- If you have not recently or ever applied for MA/MNCare you will be asked to do so before being allowed to apply for the sliding fee scale program.
- A completed enrollment form, signed by all adult household members.

PROCEDURE

- Provide all the required documentation to the Clinic by mail, email or hand delivered prior to the first appointment if possible.
- Upon review of the documents by the Clinic Director you will be notified by phone or mail as to the outcome of your application. Additional information may be requested and/or a confidential meeting with the Clinic's Executive Director.

**Please note – Family/household size MUST be reported accurately. Family is defined for these purposes as mother, father, children, significant other, husband, wife, dependent adult or child who is supported by the family. ALL income and/or family/household size, marital changes must be reported promptly to the clinic. ALL contact information must be updated with changes.

**All information received is considered confidential. You may ask us for a copy of our Privacy Policy.

2209 Jefferson Street #101A, Alexandria, MN 56308
320-815-5711 ◊ email: frontdesk@caringhandsdc.org
www.caringhandsdentalclinic.com

301 11th Street NE Pipestone, MN 56164
507-690-1745 ◊ email: pipestone@caringhandsdc.com
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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 _____

for office use only
Total in household _____
Annual gross income of all members $ _____
Qualified for Fee Scale?
YES / NO
By:_____

Best Daytime Phone: _____

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 MA or MNCare? 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.

Signature_____Date_____

Signature_____Date_____

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