Financial Assistance Program Application

Patient Name: _____

Applicant Name (if different):_____Applicant's Relationship to Patient: _____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Email:_____

Date of Birth:_____

Marital Status (optional): Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Can you be claimed as a dependent (optional)? Yes ☐ No ☐

Are you a student (optional)? No ☐ Yes ☐ Are you homeless/doubling up (optional)? Yes ☐ No ☐

Do you have dental insurance (optional)? Yes ☐ No ☐ Name of insurance plan (optional):_____

Have you applied for state health care (optional)? Yes ☐ No ☐ Date applied (optional):_____

If you have been denied, why (optional)?_____

Household Members

Name	Relationship	Birth Date (MM/DD/YY)	Annual Income	Social Security# (optional)

Household Income

Salary/Wages #:_____Self-Employment: _____

Unearned/Other:_____Annual income: _____

Provide one of the following: prior year tax return, W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals shall submit detail of the most recent three months of income and expenses for the business.

Signature

Confirmation and Acknowledgment: I hereby confirm that to the best of my knowledge, the information provided above is true and correct. I agree to inform SmileKeepers/Gentle Dental of any changes in my employment or financial situation. I understand that if the information that I have provided is later found to be incorrect, then my participation in the Program will be terminated and that any discounts provided to me will be withdrawn. In that event, I understand that I would be responsible for the full cost of any services that have been provided to me.

Signature:_____Date: _____