Siskiyou Community Health Center

DENTAL PREVENTION

Sliding Discount Eligibility Application

Siskiyou Community Health Center wants to provide health care to our patients, regardless of their ability to pay. The Dental Prevention Sliding Discount Program is based solely on family size and income in relation to the federal poverty level for dental services provided by our staff at your child's school or day care center.

If eligible, your child will receive dental education and prevention services free of charge. This eligibility is valid for the day of the dental prevention service only. Complete the below application, including signature and date, in order to be considered for this discount. You must list all household members and the monthly gross income for all adults in the household.

Student's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____

List household members. This includes yourself, spouse and dependents under 19 years old. Other adults in the household, even if related, are not included and will be considered separately.

Name (First and Last)	Relationship	Date of Birth	Gross Monthly Income
	SELF		

I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.

Signature (Parent/Guardian) _____ Date _____

Print Name (Parent/Guardian) _____

FOR OFFICE USE ONLY

DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): _____ Documented Family Annual Income: $_____

Qualifies for Slide: ❒ Yes ❒ No

% Discount (circle):

Dental Prevention **100(A)** **100(B)** **100(C)** **100(D)** **0 (Full)**

_____ _____

Siskiyou Community Health Center Signature **Date**