# Community Health and Dental Care, Inc.

**Healthcare Discount Application**

***Please fill out the application completely and attach all income information.***

**PERSONAL INFORMATION**

| | |
|---|---|
| Last Name: | First Name: |
| Date of Birth: | Social Security Number: |
| Home Address: | Home Phone Number: |
| | Cell Phone Number: |
| City/State/Zip: | E-Mail: |

**HOUSEHOLD INFORMATION** - List household members claimed on tax form (1040, 1040A and/or 1040EZ) and/or other forms

| NAME | SOCIAL SECURITY NO. | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|---|
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I have completed this application for healthcare discount eligibility and confirm that all my information is correct to the best of my knowledge. I understand a minimum payment of $20.00 for Medical/Vision/BH, $35.00 for Dental Services and $5.00 for Pharmacy will be collected at the time of each visit. I understand that discounts are available regardless of my insurance status and if I do not qualify for a discount, I will be responsible to pay 100% of billed charges. For example, if I am eligible for an 80% discount I will be responsible for 20% of the applicable charges. I am aware that this discount does not apply to Dental and Medical lab fees. I understand for self-declared individuals that my slide discount may change subject to administrative approval.

☐ Community Health and Dental Care has offered and explained to me the benefits of applying for the healthcare discount. At this time I choose not to apply for the healthcare discount. I understand that I may apply at any time should I change my mind or my personal situation changes such as household size, insurance status and/or gross income.

APPLICANTS SIGNATURE: _____ Date: _____

**DO NOT FILL OUT BELOW THIS LINE -ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY**

**PROOF OF INCOME**

☐ Most recent Income Tax Returns (1040, 1040A, 1040EZ; applicable adjusted gross income line)

☐ Two recent pay stubs (check one) ___Weekly___Biweekly___Monthly

☐ Social Security/Disability letters

☐ Proof of Residency

☐ Other: _____

Annual Gross Income $ _____ Family Size: _____

**Patient discount applied to applicable charges:**

Medical/Vision Discount: ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐ 0%

Dental Discount: ☐ 100% ☐ 70% ☐ 55% ☐ 40% ☐ 25% ☐ 0%

Pharmacy Discount: ☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐ 0%

Processed by: _____ Date: _____