



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

Please check the statement that best describe your housing situation:

- I live in my home which I rent, lease or own
- I live with family members and do not have any housing costs
- I am staying with a series of friends and/or extended family members on a temporary basis
- I am staying in supportive or transitional housing (such as a sober living facility or recovery home)
- I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility or motel)
- I have been released from an institution (such as jail or hospital) without stable housing to return to
- I live on the streets, in a car, park, sidewalk, in an abandoned building or any unstable or non-permanent situation
- I live in a foster care environment

Circle the amount that is closest to your household income

\$12,000	\$13,500	\$15,000	\$16,500	\$18,000	\$19,500	\$21,000	\$22,500	\$24,000	\$25,500
\$27,000	\$28,500	\$30,000	\$31,500	\$33,000	\$34,500	\$36,000	\$37,500	\$39,000	\$40,500
\$42,000	\$43,500	\$45,000	\$46,500	\$48,000	\$49,500	\$51,000	\$52,500	\$54,000	\$55,500
\$57,000	\$58,500	\$60,000	\$61,500	\$63,000	\$64,500	\$66,000	\$67,500	\$69,000	\$70,500
\$72,000	\$73,500	\$75,000	\$76,500	\$78,000	\$79,500	\$81,000	\$82,500	\$84,000	\$85,500

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 Dispensary 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%

Dispensary Discount: 100% 80% 60% 40% 20% 0%

Processed by: _____

Date: _____