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:	Email:

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 is 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

CHDC
Your Health.
Our Community.

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: ______________