Instructions for Sliding Fee Scale Qualifications

On the next pages are three different forms for uninsured patients. **You do not need to fill out all the forms.** Choose the form that is right for you based on the following guidelines**.**

1) **"Sliding Fee Scale Qualification form":** please fill out this form if you are able to provide a *check stub, a W2 form, or a bank statement* that shows the monthly income of the individuals in your household. If you are employed, on disability, or receive unemployment payments you may use this form. If you do not have a check stub, W2, or bank statement for one individual in your household, you may substitute the form titled **"Employment and Wage Verification Form."**

2) **"Employment and Wage Verification Form":** if you do not have access to one of the documents listed above, but are employed, please fill out the top portion of this form and have your employer complete the bottom portion, then bring it to when you come during eligibility hours.

3) **"Income Assistance Verification Form":** if you do not have a regular source of income, but receive assistance from a government or community organization, please use this form. The form must be completed by someone who is not related to you and who can confirm that you require financial assistance.

SLIDING FEE SCALE QUALIFICATION FORM

Patient Full Name: _____ Date of Birth:_____

Responsible Party: _____

COMBINED GROSS INCOME OF ALL FAMILY MEMBERS IN HOUSEHOLD VERIFIED BY:

_____ Check Stubs

_____ Bank Statement

_____ W2

_____ Number in Household

SLIDING SCALE PLACEMENT PERCENTAGE _____

I attest that all statements attached to this document are true and correct to the best of my knowledge. I have reported all income sources to Wilkes Public Health Dental Clinic and have correctly listed all dependents in the household. I understand this information may include medical or non-medical information including such collateral sources as banks, employers, and insurance companies. If any of the information changes, I understand I am to report this to the Financial Coordinator at the next visit. This procedure must be updated yearly. Should it come to our knowledge that the information provided is fraudulent or misleading, the patient will not be allowed to use the Sliding Fee Scale and will placed at 100% of fee as long as they remain a patient.

X _____ Date _____
(Signature of Patient/Parent/Guardian)

Financial Coordinator: _____

EMPLOYMENT AND WAGE VERIFICATION FORM

I, _____, authorize my employer, _____,
(Employee Name) (Company Name)

to release information regarding my income to the Wilkes Public Health Dental Clinic.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Patient Phone Number

Beginning date of employment: _____ Date of first pay: _____

Hourly wage: _____ Number of hours employee works weekly: _____

How often paid? (Circle one) Weekly Bi-weekly Monthly Other: _____

What day of the week is pay received? _____

Do you expect any changes in rate of pay or hours worked? Yes No **If Yes,** explain: _____
_____

Does your employee receive bonuses? Yes No **If Yes,** how often are they received: (Circle one)
Yearly Every 6 months Other: _____

Does your employee have health insurance? Yes No **If Yes,** name of company: _____
_____

Is employee on paid leave of absence? Yes No

_____
Employer's Name and Title (Printed)

_____ _____ _____
Employer's Signature Phone Number Date

(This information is for the Wilkes Public Health Dental Clinic use only)

INCOME ASSISTANCE VERIFICATION FORM

We are trying to determine the eligibility of _____ for services at the Wilkes Public Health Dental Clinic.

_____ reports her/him and her/his family has little or no income. Before we can determine eligibility, we need a third party to confirm this. By signing this letter, you are confirming that to the best of your knowledge, this individual/family has little or no income.

Thank you for helping us determine eligibility for this individual/family through our programs. If you have any questions, please call 336-903-9399 or fax information to 336-903-7313.

_____ _____ _____
Staff Signature Title Date

RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months.

_____ _____
Client Signature Date

Please complete the following:

Date of Assistance _____ Amount Per Month

Income: Source _____ $_____

Source_____ $_____

Comments: _____

_____ _____
Third-Party Signature Date

_____ _____
Print Third-Party Name Individual/Agency/Organization

Third-Party Address _____

_____

Third-Party Phone # _____

For applicants with no income see statement on back

Applicants reporting no income must have a Third Party Conformation Letter completed by a reliable third party knowledgeable of the applicant's family income. Reliable third parties are limited to staff of a social service agency, Employment Security Commission, foster care program, church, relief organization, legal aid society, or school counselors. Relatives of the applicant or WPHDC employees cannot be third party verifiers. The Third Party Confirmation Letter must be signed, dated, and include a telephone number.