Children's Dental Services

Sliding Scale Fee Application

Head of Household Information			Today's Date: / /
First Name:	Last Name:		Date of Birth: / /
Address:	City:	State:	Zip:
Home Phone #: ( )		Other Phone #: ( )	

Do you or anyone in the family have Medical or Dental insurance?	Have you applied for Medical Assistance or any other State Assistance in the last year?	Are you or anyone in the family in need of Emergency Medical Assistance?
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
If yes, who:_____	**If you have been denied, please attach a copy of the denial letter.**	If yes, who:_____

Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Household Information

Please list the name and date of birth of everyone living in the household

First and Last Name	Date of Birth	Relationship	Applying for Sliding Scale?
	/ /		☐ Yes ☐ No
	/ /		☐ Yes ☐ No
	/ /		☐ Yes ☐ No
	/ /		☐ Yes ☐ No
	/ /		☐ Yes ☐ No
	/ /		☐ Yes ☐ No
	/ /		☐ Yes ☐ No

Household Income

Please list all adult family members below and their employment status. If a family member has more than one job, please list separately.

First and Last Name	Is this person working or has worked in the past two months?	How often paid?*	Place of employment
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

*** If you receive or have received cash in the last two months, please fill out Form SS-A**

Tax information		
Did you file last year's taxes?	☐ ***Yes*** ***(include 1040 or 1040A)***	☐ ***No***

I certify that the IRS forms that I submitted to Children's Dental Services are a true copy of the forms submitted to the IRS, and that the pay stubs and/or the SS-A or SS-B forms that I submitted to Children's Dental Services are true representations of our income. I certify that I have provided Children's Dental Services true and complete documentation of all the family's sources of income. If there is a change in the family's income, I understand that I am responsible to notify Children's Dent al Services within 30 days and that my discount will be re-evaluated.

I understand that I am responsible for all charges accrued. I am aware that I/my children may not be given future appointments and/or service until the outstanding balance is paid in full. I understand that my discount may be revoked retroactively if the information I have provided is false or incomplete, or if I fail to notify Children's Dental Services of a change of income. In this case, I would be responsible to pay the back charges on my family's account.

Parent's Signature:_____ Date: _____

CDS Staff Processing Application:_____ Date: _____

This section is for Office Use Only

This application is approved:

Percentage_____

Effective Date: _____

Retroactive Date: _____

Expiration Date: _____

This application is denied:

Denial Reason:_____

Name of Reviewer:_____ **Date:** _____

Additional Notes:

DIRECTIONS FOR COMPLETING THE SLIDING SCALE FEE APPLICATION

Head of Household Information:

1. Complete the head of household's name and date of birth.
2. Complete the head of household's address, phone numbers and marital status.
3. Complete the head of household's insurance information, whether they have applied for Medical Assistance, or are in need of Emergency Assistance.

    *** If denied for Medical Assistance include a copy of denial letter.**

Household Information:

1. List the name and date of birth of each member of the household. Check yes or no if they are applying for the sliding program. Patients are eligible to receive sliding scale discounts until they are 21 years and 1 month old.

Household Income:

1. Check YES if anyone in the household is or has worked in the past two months.
2. Fill out employee name, how often paid, receiving cash or paystubs, and employer information.

    ***Include a copy of 2 months of paystubs.**
    ***Fill out Form SS-A if working for cash.**

Tax Information:

1. Check **YES** if you have filed last year's tax return and **attach a copy of your 1040 or 1040A with application.**
2. Check **NO** if you have not filed last year's tax return.

Document Checklist

In order to process your application, we need the following documents:

- ☐ Rejection letter from Minnesota Medical Assistance dated within the last 12 months
- ☐ Most recent income tax forms- form 1040 or form 1040A.
- ☐ Pay stubs for the last two months - for all working members in household.
- ☐ Sign Form SS-A (Employer Statement for Verification of Wages – if applicable)
- ☐ Other_____

**PLEASE PROVIDE THE REQUESTED INFORMATION WITHIN 30 DAYS. FAILURE TO DO SO MAY VOID YOUR APPLICATION.