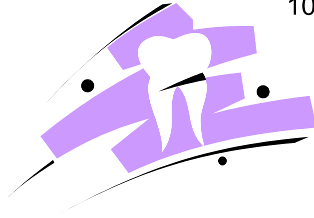
The Dental Health Clinic



107 South Market Street, Suite 2
Berwick PA 18603
Phone (570) 752-8753
Fax (570) 759-6372

SLIDING FEE APPLICATION

Name of Head of Household			Place of Employment		
Street Address	City	State	Zip	County	Phone
Health/Dental Insurance Plan			Social Security Number		

Please list spouse and dependents under age 18 **Total number in household** ______

Spouse Name:	Date of Birth:	Dependent:	Date of Birth:
Dependent:	Date of Birth:		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Social Security, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments				
Income from self employment				
Rent, interest, dividends, and other income				
Total Income				

Verification (attach copies)

To be considered for discounted rates you MUST include the following with your application:
A copy of the most recent Federal tax return.
Copies of the last 2 months of income stubs (including wages, social security, unemployment comp, etc).
Proof of identification (example: copy of driver's license).
Proof of Medicaid application (include copy of denial letter if you do not qualify for Medical Assistance).

I certify that the above information is true to the best of my knowledge. I also agree to inform the Dental Health Clinic of any changes in my income. I give the Dental Health Clinic permission to verify any information given on this form with a third party agency.

______________________________ ______________________________
Name (print) Signature and date

Please call 752-8753 two weeks after submitting application to verify that you qualify for sliding fee scale.

Payments are due on the day of treatment. We accept cash, check, and most credit cards.