

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	

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).

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 (570) 752-8753 after submitting this 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.