



Dental Clinic Eligibility Application

To be considered for discounted rates for dental services with Augusta Regional Dental Clinic the following application must be completed and updated annually.

- **If you have CURRENT Financial Assistance with Augusta Health or Medicaid, please stop filling out this form and call the Dental Clinic at 540-221-6635.**
- **Attach your paycheck stubs (and your spouse or domestic partner's) for the most recent month**
 - If you do not have traditional paystubs you must have your employer write a letter verifying wages for the past month
 - If you have NO income you must have a "Letter of Support" completed by the person who is financially supporting you
 - If you do not attach your proof of income your application will not be processed
- **Attach your most recent tax return**
 - If you did not file taxes this year, please indicate so on the application form
 - If you did file taxes, you must attach your most recent tax return or your application will not be processed
- **Mail all information to the Augusta Regional Dental Clinic P.O. Box 153, Fishersville VA, 22939**
 - You may also bring completed application directly to clinic and place in outdoor drop box located near the front door
- **Your application will be processed and a determination letter will be mailed to the address on the application**
- **Approvals are effective for a period of one year**
- **All dental appointments must be paid for in advance**
- **Any families with income *above* 300% of the Federal Poverty Guidelines will not be eligible for dental services at Augusta Regional Dental Clinic**

Household Size	0- 250% \$45 co-pay	251-300% \$75 co-pay
1	\$31,900	\$38,280
2	\$43,100	\$51,720
3	\$54,300	\$65,160
4	\$65,500	\$78,600
5	\$76,700	\$92,040
6	\$87,900	\$105,480
7	\$99,100	\$118,920
8	\$110,300	\$132,360

DENTAL CLINIC ELIGIBILITY APPLICATION

Do not leave any fields blank. If it is not applicable to you, write N/A. Incomplete applications will *not* be processed.

Applicant's Information

Applicant's Full Name _____
Date of Birth _____ SSN _____
Street Address _____
City, State, Zip Code _____
Phone Number _____
Gender _____ Ethnicity _____

Marital Status:

Single Married Divorced Widowed

Employment Status:

Full-time Part-time Self-Employed Unemployed Student

Employer's Name _____
Phone Number _____

Do you have dental insurance?

Yes No

If yes, what type?

Medicaid Private Insurance (Delta, Aetna, Cigna, Anthem, etc)

Did you file taxes last year?

Yes No

Spouse or Domestic Partner's Information

(If you do not have a spouse or domestic partner you do not need to complete this portion)

Spouse or Domestic Partner's Full Name _____
Date of Birth _____ SSN _____
Street Address _____
City, State, Zip Code _____
Phone Number _____
Gender _____ Ethnicity _____

Spouse or Domestic Partner's Employment Status:

Full-time Part-time Self-Employed Unemployed Student

Employer's Name _____
Phone Number _____

Does Spouse or Domestic Partner have dental insurance?

Yes No

If yes, what type? Medicaid Private Insurance (Delta, Aetna, Cigna, Anthem, etc)

Did you file taxes last year?

Yes No

Dependent Information (List all those under your legal guardianship *living with you*)

Dependent's Name	Date of Birth	Relationship	SSN	Name of Dental Insurance (if any)

INCOME INFORMATION

IF YOU HAVE NO SOURCE OF INCOME PLEASE COMPLETE A "LETTER OF SUPPORT" TO BE COMPLETED BY THE PERSON WHO IS SUPPORTING YOU AT THIS TIME.

Applicant's Source of Income

(Complete all that apply and provide documentation for each applicable item below)

Indicate all sources of income you receive	How often do you receive it?			Gross Amount
	Weekly []	Bi-Weekly[]	Monthly []	
Wages or Self-Employment Income	Weekly []	Bi-Weekly[]	Monthly []	\$
Social Security Income	Weekly []	Bi-Weekly[]	Monthly []	\$
Retirement	Weekly []	Bi-Weekly[]	Monthly []	\$
Pension	Weekly []	Bi-Weekly[]	Monthly []	\$
Food Stamps	Weekly []	Bi-Weekly[]	Monthly []	\$
Alimony or Child Support	Weekly []	Bi-Weekly[]	Monthly []	\$
Unemployment Benefits	Weekly []	Bi-Weekly[]	Monthly []	\$

Spouse or Domestic Partner's Source of Income

(Complete all that apply and provide documentation for each applicable item below)

Indicate all sources of income you receive	How often do you receive it?			Gross Amount
Wages or Self-Employment Income	Weekly []	Bi-Weekly[]	Monthly []	\$
Social Security Income	Weekly []	Bi-Weekly[]	Monthly []	\$
Retirement	Weekly []	Bi-Weekly[]	Monthly []	\$
Pension	Weekly []	Bi-Weekly[]	Monthly []	\$
Food Stamps	Weekly []	Bi-Weekly[]	Monthly []	\$
Alimony or Child Support	Weekly []	Bi-Weekly[]	Monthly []	\$
Unemployment Benefits	Weekly []	Bi-Weekly[]	Monthly []	\$

CHECKLIST BEFORE SUBMITTING APPLICATION

- Attach your paycheck stubs for the past month (or a letter of support from whoever is supporting you financially)
- Attach your spouse or domestic partner’s paycheck stubs for the past month
- Attach your most recent tax return
- Attach any additional proof of income if applicable (including verification of Social Security/Disability Benefits, Retirement, Pension, Alimony or Child Support, Unemployment Benefits)
- This completed application

Acknowledgment

I acknowledge that the information provided is true and accurate to the very best of my knowledge. I understand that if any information is found to be false that this application will be denied. By signing below, I authorize Augusta Regional Dental Clinic to verify information provided in this application with listed employers or other listed agencies. I understand that I may be asked to provide more information. I understand that a letter of determination will be mailed to the address provided on this form in a timely manner.

Applicant’s Signature _____
 Date _____

Spouse or Domestic Partner's Signature _____
Date _____