Revised 2-2-19

Oral Health Task Force

Sliding Scale: Statement of Financial Position

PLEASE PRINT –

Applicant's Name_____ **Date of Birth** _____
Spouse's Name _____ **Date of Birth** _____
Address _____
Home Number _____**Cell Number**_____ **Work Number** _____
Work Number (Spouse)_____ **Email Address** _____

Family children and young adults (18 months to 26 years of age)

First Name	**Birth Date**	**Last Name if Different**
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach separate sheet if more space is needed)

Circle the option that best describes your situation. I have: Dental insurance…..Medical insurance..... Both…..Neither…..

If you have dental insurance, please list your insurance carrier: _____Group #_____Policy _____

If you are uninsured or struggle to afford your health and dental care, you may be eligible for Sawtooth Mountain Clinic's Sliding Fee Scale Program or for Medical Assistance. Please call Erin at Sawtooth Mountain Clinic (218 387-2330) to learn more about these programs and how to apply.

Are you eligible for the Sawtooth Mountain Clinic Sliding Fee Scale Program? (See attached) _____ If so, an application needs to be filled out along with financial verification. The clinic becomes the primary health care provider and Oral Health Task Force becomes the secondary provider. Any outstanding balance due, will be billed to the patient by Sawtooth Mountain Clinic.

Family income for past 12 months from all jobs _____ Attached proof of income i.e. latest Federal Income Tax Statement 1040 showing your adjusted gross income which is usually on the 1st page or W2.

I hereby acknowledge that I have read these instructions: The Oral Health Task Force, Grand Marais Family Dentistry and the Sawtooth Mountain Clinic may share my income information to determine program availability. I understand that the Oral Health Task Force's sliding scale of assistance is a defined program with service and payment limits. The Task Force will not be responsible for bills which I may incur outside of the specified limits. I hereby swear that the above information is correct as stated. Falsifying this information is a crime punishable by law.

_____ _____ _____
Signature **Spouse's signature if applicable** **Date**

Oral Health Task Force Sliding Fee Scale as of November 1, 2014 to present – Income Eligibility

Family size	*Patient pays 5% of charge*	*Patient pays 25% of charge*	*Patient pays 50% of charge*	*Patient pays 75% of charge*	*Patient pays 100% of charge*
1	0-35,010	35,011-46,565	46,566-58,207	58,208-69,850	69,851+
2	0-47,190	47,191-62,764	62,765-78,456	78,457-94,149	94,150+
3	0-59,370	59,371-78,963	78,964-98,706	98,707-118,448	118,449+
4	0-71,550	71,551-95,163	95,164-118,955	118,956-142,747	142,748+
5	0-83,730	83,731-111,362	111,363-139,204	139,205-167,046	167,046+
6	0-95,910	95,911-127,562	127,563-159,453	159,454-191,345	191,346+
7	0-108,090	108,091-143,761	143,762-179,703	179,704-215,644	215,645+
8	0-120,270	120,271-159.960	159.961-199,952	199,953-239,943	239,944+

TRANSPORTATION IS AVAILABLE FROM THE SCHOOL TO THE DENTAL OFFICE AND BACK. CALL THE OFFICE FOR MORE INFORMATION….387-2334

Office Use	
Family Income	
Patient pays	%
Sliding Fee Pays	%