Gentle Dental

Financial Assistance Program Application

Patient Name: _____

Applicant Name (if different): _____ Applicant's Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Marital Status: _____

Social Security #: _____ Can you be claimed as a dependent? Yes ☐ No ☐

Are you a student? Yes ☐ No ☐ Are you homeless/doubling up? Yes ☐ No ☐

Do you have dental insurance? Yes ☐ No ☐ Name of insurance plan: _____

Have you applied for state health care (Oregon Health Plan)? Yes ☐ No ☐ Date applied: _____

If you have been denied, why: _____

Household Members

Name	Relationship	Birth Date (MM/DD/YY)	Annual Income	Social Security #

Household Income

Salary/Wages #: _____ Self-Employment: _____

Unearned/Other: _____ Annual income: _____

Provide one of the following: prior year tax return, W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals shall submit detail of the most recent three months of income and expenses for the business.

Signature

Confirmation and Acknowledgment: I hereby confirm that to the best of my knowledge, the information provided above is true and correct. I agree to inform Gentle Dental of any changes in my employment or financial situation. I understand that if the information that I have provided is later found to be incorrect, then my participation in the Program will be terminated and that any discounts provided to me will be withdrawn. In that event, I understand that I would be responsible for the full cost of any services that have been provided to me.

Signature: _____ Date: _____