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 SmileKeepers 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to be incorrect, then my participation in the Program will be terminated and that any discounts provided to me will be withdrawn.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: ______________