515 State St. P.O. Box 177 Atwood, KS 67730
785.626.8290 Fax: 785.626.8332

Application for Sliding Fee Scale

To qualify for a discount, you must complete this application and attach **3 months proof of income**. If you have no income, a letter verifying this status is required. You must return this application to Rawlins County Dental Clinic (RCDC) within one week to determine your eligibility. If you qualify, your discount will be in effect for **one year from the date of your application**. If your income or household changes, please notify RCDC to be sure you are receiving the proper discount. When your discount expires, you will need to reapply. Please call our office if you have any questions.

Name:____

Address:____

Phone:____

Please list everyone living in your home starting with yourself:

Name: Age & Birth date Relationship to you

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

Please continue application on the back.

List **everyone** in the household receiving income (household income includes all income generated by the household, **regardless of marital status)**. Income is, but is not limited to: salaries, pensions, social security, disability, alimony, child support, unemployment, self-employment, tips, VA benefits, etc. ***Three months proof of income is required to process the application.*** **Approval will not be granted without documentation of income. You will be responsible for full fees if proper documentation is not provided within one week from application.**

Name of person working Receiving income.	Type of income	Employer name & phone Number	Monthly amount received **before** taxes/deductions

I understand that any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts. I agree to pay at the time of service. I certify the above information is correct and assume the responsibility of contacting Rawlins County Dental Clinic should any changes occur.

____

Patient's Signature   Date

FOR OFFICE USE ONLY:

____

Date application Received: ____

Total Verified income: ____/month/year

Benefit Qualified For: ____

Expiration Date: ____

____

Signature of Rawlins County Dental Personnel