Affordable Dental Services Application

The application for affordable dental services must be completed to its entirety before any member of the household will be approved for our affordable services. Proof of pay is required and all documentation must accompany the application.

Applicant's Full Name:	Date of Birth:
Address 1(mailing):	City, State, VA:
Address 2 (physical):	
Primary Phone Number:	Other Phone:
Marital Status: please circle Single Married Widowed Divorced	Email:
Are you currently working: _ Yes _No Employer:	Frequency of Pay: please circle Weekly Biweekly Monthly Other: _______
Do you have dental insurance? _Yes __No	
If you are unemployed and do not receive any income, does someone provide support for you? ___ Yes ___No If Yes you will need to provide proof of your supporter's income or a letter of support.	
Has the applicant been screened for Medicaid, FAMIS, or other assistance by the Department of Social Services? __ Yes ___No If you answered yes, why does the patient not receive the above assistance? If no, would you be interested in additional information? _Yes __No	

Household Information must be completed for all applicants

List all members of household, date of birth, and relationship.

Applicant's Full Name:	Date of Birth:	Relationship:
Full Name:	Date of Birth:	Relationship:
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Household Income (Proof of Income must be copied and attached)

Household income is defined as all income coming in to the home including but not limited to wages earned through employment, government assistance (social security, food stamps, etc.), disability (short or long term) and unemployment benefits. You must provide proof of one month's worth of income from all sources. You may use the previous year's 1040 tax form if that more accurately reflects your household.

Please complete the information below:

	Self	Spouse	Other	Total
Employment Wages				
Tips				
Unemployment Benefits				
Social Security				
Pension Benefits				
Trust fund Disbursement				
Scholarships				
Food Stamps				
Child Support				
Public Assistance				
Housing allowance				
Military Family Allotment				
VA Benefits				
Grants				
Rental Income				
Financial Support from family				
Other:				
Totals				

Affidavit: By signing, I attest that as of the date of my signature, the income sources listed are all of my household income, the household members listed are all solely dependent on that income, and the explanation provided to verify my income level is true. I understand that if the information provided is found to be incomplete or fraudulent I will be removed from the sliding scale permanently.

Applicant / Responsible Party Signature: ____________________________________ Date: ____________

PRDC STAFF ONLY TO FILL OUT THIS SECTION:
Total Monthly Household Income: $_________________ # of people in household: ________
Total Annual Household Income: $_________________ Tier: _______________
Valid Until: _________________________ Office Staff Signature: __________________________________

Revised 5/2013