Marian Dental
CLINIC | SCL Health

HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

Patient name_____ **Account #**_____

Date of Birth_____

Address_____

City_____ State_____ Zip_____ County_____

Home phone _____ Cell phone_____ Work phone_____

Email_____

☐ Single ☐ Married/Significant other ☐ Divorced/Separated ☐ Widow/Widower

Responsible party name_____ Relationship_____

Date of Birth_____

Address_____

Home phone _____ Cell phone_____ Work phone_____

Spouse name _____ Date of Birth_____

Address_____

Home phone _____ Cell phone_____ Work phone_____

List dependents living with you for whom you are responsible. Please include name(s), age(s) and DOB:

_____ _____

_____ _____

_____ _____

_____ _____

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that SCL Health requires verification of income before any determination is made. I also understand that my credit may be accessed, at no expense to me, to verify the above information.

Patient signature (legal guardian)_____ **Date**_____

FOR OFFICE USE ONLY

☐ Completed, signed and dated application

☐ At least one of the following, documenting income for the last 3 months OR last year's tax return:
- Copy of pay stubs for patient, spouse and/or significant other
- Copy of award letter(s) – Unemployment, Social Security, etc., displaying monthly benefit
- Copy of bank statements

☐ Copy of valid photo ID: Driver's License, Passport, Visa, etc.

Family Size_____ Income_____ Poverty Level %_____ Sliding Scale Level_____

Special notes:_____

Office associate name:_____ APPROVE DENIED Date:_____