MISSION EAST DALLAS
FAMILY MEDICAL & DENTAL CENTER

Sliding Fee Scale Application

Applicant Information			
Name (Last, First, Middle	Date of Birth: / /	Social Security #	
Home Address:	City:	State:	Zip:
Mailing Address: (*If different than home address)*	City:	State:	Zip:
Best Contact # ( )	Email:		
Marital Status (circle one): Single In a relationship Married Divorced Separated Widowed			

Circle any benefits, programs, or health Insurance(s) that you or anyone in your household have:

Medicaid Medicare CHIP Texas Women's Health Program SNAP
TANF WIC VA Health Benefits Private Health Insurance Dental Insurance

Household Information: List everyone who lives with you, with whom you share expenses & provide financial support:

Name	Birthdate	SSN	Sex	Relationship
1.				
2.				
3.				
4.				
5.				
6.				
Total Family Size:				

Household Income-- List any household member's income below. Include government checks, money from work, retirement pensions, alimony, monthly cash contributions, child support, and unemployment benefits

Name of Person Receiving Money	Amount	Frequency (Circle one)	Type of Income
1.	$	Weekly Bi Weekly Monthly Yearly	
2.	$	Weekly Bi Weekly Monthly Yearly	
3.	$	Weekly Bi Weekly Monthly Yearly	
4.	$	Weekly Bi Weekly Monthly Yearly	
5.	$	Weekly Bi Weekly Monthly Yearly	

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Mission East Dallas if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Mission East Dallas I hereby acknowledge that I read the foregoing disclosure and understand it.

Name -Print:_____Signature:_____Date:_____

Updated 8.10.2018

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For Office Use Only

Sliding Fee Scale Assignment_____ Effective Date_____

Approved by Enroller _____ Date_____

Verification Checklist (Attach Copies)	YES / Amount Used
New Application	
Recertification	
Valid Identification: Government Issued with photo, current w/in last 5 years	
Income: Prior year tax return (1040 Form), 2 most recent pay stubs	
Income Verification Amount – Household Member 1	$
Income Verification Amount – Household Member 2	$
Additional Adult Income Verification Amount – Household Member 3	$
Additional Adult Income Verification Amount – Household Member 4	$
Additional Adult Income Verification Amount – Household Member 5	$

Family Size (see Household Info) _____ (log as "Dependents" in eCW)

Gross Income (Annually) $ _____ (1+2+3+4+5)

Enrolled Household Members
(see Household Info – must be logged in eCW)

1. _____
2. _____
3. _____
4. _____
5. _____

Date Welcome Packet Given/Initials _____ (document in Misc. Info on "Patient Informtion" tab in chart)