Cleveland Avenue Dental Center
501 N. Cleveland Avenue, Suite 1
Winston-Salem, NC 27101
336-703-3090

Sliding Fee Discount Application

I confirm that the information below is correct and accurate to the best of my knowledge. I have reported all income sources to Cleveland Avenue Dental Center and have correctly listed all household members. If any information changes (number living in household, annual income, etc.), I understand I am to report this to the Front Office at the next visit. This application must be updated yearly. Should it come to our knowledge that the information provided is fraudulent or misleading, the patient will not be allowed to use the Sliding Fee Scale and will be placed at 100% as long as they remain a patient.

Patient Full Name: _____ Date of Birth: _____

Responsible Party (if patient is a minor): _____

Employer Name: _____

Address: _____ Phone Number: _____

DOCUMENTATION OF INCOME

_____ Check Stubs

_____ Supplemental Security Income (SSI)

_____ Unemployment Compensation

_____ Veteran's Administration Benefits

_____ Employer Verification Form

_____ Social Security Benefits

_____ Other (please list): _____

_____ Number in Household

_____ Number that work in Household

_____ Total Yearly Income of Household

Office Use Only

Sliding Scale Placement Percentage: _____ Staff Initial: _____

I understand that I am financially responsible for all charges.

X _____ Date_____
(Signature of Patient/Parent)

X _____ Date _____
(Dental Center Representative)

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WAGE VERIFICATION FORM

I hereby authorize my employer to release the following information to the Forsyth County Department of Public Health.

_____
Client signature Date

The following should be completed by the employer.

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Employee's Name: _____

Start Date: _____

Gross Salary: _____ Hourly Rate: _____

Pay period: _____ Frequency: _____

If irregular schedule: Average hours worked per week _____

Average weeks worked per year _____

Comments: _____

_____

Employer Signature: _____

Title: _____ Date: _____

****For any questions, please call Madelin or Darlene at 703-3090.****

This form should be completed within the next 30 days. Date: _____

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Verification of Family Income

Please fill out the information below regarding the income of the entire household. The household includes all members living in the house. The family income is considered all income brought in by all members of the household.

Patient Full Name: _____ Date of Birth: _____

Income Worksheet:

Name of Each Family Member	Income of Each Family Member
Total Income (add all incomes):	

_____ Number in Household
If additional household members, please attach sheet.

_____ Income of Household (Combined Income of All Members of the Family)

I confirm that this information is correct and accurate to the best of my knowledge. I have reported all income sources to the Cleveland Avenue Dental Center. If any information changes, I will report this to the Front Office at the next visit.

_____ _____
Signature of Family Member **Date**

_____
Printed Name of Family Member

Sources of Income Include (but are not limited to): salaries, wages, public assistance monies, earnings from self-employment, unemployment compensation, alimony, Social Security benefits,

Supplemental Security Income (SSI), Veteran's Administration (VA) benefits, Workers compensation