# Income Worksheet

A minimum co-pay of $50 will be charged for each clinic procedure. Charges for the services provided may be discounted based on your income and family size. Full payment is requested at the time of visit.

| | | | | |
|---|---|---|---|---|
| Name | | | | |
| Address | City | | State | Zip Code |
| Home Phone | Work Phone | Occupation | Name of Employer | |
| Date of Birth | Sex<br>❒ Male ❒ Female | Marital Status<br>❒ Single ❒ Married<br>❒ Divorced ❒ Widow/Widower | Race | |

Please complete the following information. Be as accurate as possible. You will be asked to provide proof of your income. (Paystub, income taxes, bank statement, letter from your employer, etc.) if you choose not to provide the financial information, you will be asked to pay the full cost of services provided.

| Wage Earner | Rate/Hour | | Hours/Week | | Total Weekly Wages |
|---|---|---|---|---|---|
| Self | | X | | = | |
| Others (Include spouse or partner if living together) | | X | | = | |
| **TOTAL** | | X | | = | |

OR

| Wage Earner | Wages/ Month | | Months/Year | | Total Yearly Wages |
|---|---|---|---|---|---|
| Self | | X | | = | |
| Others (Include spouse or partner if living together) | | X | | = | |
| **TOTAL** | | X | | = | |

List amount received per month from other sources of income:

| | | | |
|---|---|---|---|
| Veteran's Benefits | $_____ | Alimony Child Support | $_____ |
| Unemployment | $_____ | Workers' Compensation | $_____ |
| Income from property | $_____ | Stipends/Grants/Scholarships | $_____ |
| Allowance | $_____ | Dividends/Interest | $_____ |
| Tips | $_____ | Retirement/Pensions | $_____ |
| Public Assistance | $_____ | Social Security | $_____ |
| Self-Employment | $_____ | Other _____ | $_____ |

| Total number of household members depending on this income: | Do you receive medical assistance? | Do you have dental insurance? |
|---|---|---|
| Insurance Company | | Company Address |
| Contract Number | | Name of Policy Holder |

**AUTHORIZATION AND ASSIGNMENT**

The preceding information is true to the best of my knowledge. I request the Bridging the Dental Gap Clinic to provide my family and I with dental care. I acknowledge my responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for dental services to be paid to Bridging the Dental Gap. I understand that failure to pay the balance of the outstanding fees owed to Bridging the Dental Gap within 90 days will result in my account being turned over to a collection agency.

Signed **X** _____ Date: _____

*For Office Use Only*

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Sliding Fee Discount _____ Interviewer's Initials _____