Health Care Collaborative of Rural Missouri
825 South Business Hwy 13, Lexington, MO. 64067 660-259-2440
Live Well Community Health Centers
Owned and operated by HCC of Rural Missouri, a Rural Health Network
608 Missouri St., Waverly, MO 64096 660-493-2262
206 N. Bismark, Concordia, MO 64020 660-463-0234
324 S. Hudson St. P.O. Box 512 Buckner, MO 64016 816-249-1521
1413 N. Jefferson St., Carrollton, MO 64633 660-329-9005

Live Well Community Health Centers Packet

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Dear Parent,

Live Well Community Centers will be offering medical/dental services in your school district this year. We will be offering a school based clinic and mobile dental unit on the school campus where medical and dental team will perform exam and needed treatment

Are you interested in your child receiving medical/dental treatment at the Orrick School District Campus based clinic?

☐ YES ☐ NO

If your answer is yes, please continue on and complete the following registration packet so that we can meet your child's dental/medical health needs. Included in the packet are documents that may qualify your child for slide fee services if you are uninsured. Please provide the financial information requested if you believe you may meet the requirements.

Best Regards,

Live Well Community Health Centers Medical/Dental Team

Dr. Geoff Peterson, D.M.D.	Dr. Doug Smith, M.D.	Shelby Spor, R.N.
Dr. David Geiger D.M.D.	Dr. Karl Grant, D.O.	
Kyra Tracy, R.D.H.	Rori Schreiman, FNP	
Jami Vandevort, R.D.H.	Kelly Seals, FNP	
Caitlin Billings, R.D.H.	Jen Patterson, FNP	

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IF UNINSURED, ARE YOU INTERESTED IN APPLYING FOR A SLIDING FEE SCALE?

❑ YES ❑ NO ❑ DECLINE

(IF YES, THIS REQUIRES PROOF oF HOUSEHOLD INCOME TO BE ATTACHED TO THIS FORM)

Family Size and Income Range

Health Care Coalition of Lafayette County						
dba/ Livewell Community Health Centers						
Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Based upon 2016 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)						
Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Slide A	Slide B	Slide C	Slide D	Slide E	Full Pay
1	$0 - $11,880	$11,881 - $14,850	$14,851 - $17,820	$17,821 - $20,790	$20,791 - $23,760	$23,761+
2	$0 - $16,020	$16,021 - $20,025	$20,026 - $24,030	$24,031 - $28,035	$28,036 - $32,040	$32,041+
3	$0 - $20,160	$20,161 - $25,200	$25,201 - $30,240	$30,241 - $35,280	$35,281 - $40,320	$40,321+
4	$0 - $24,300	$24,301 - $30,375	$30,376 - $36,450	$36,451 - $42,525	$42,526 - $48,600	$48,601+
5	$0 - $28,440	$28,441 - $35,500	$35,501 - $42,660	$42,661 - $49,770	$49,771 - $56,880	$56,881+
6	$0 - $32,580	$32,581 - $40,625	$40,626 - $48,870	$48,871 - $57,015	$57,016 - $65,160	$65,161+
7	$0 - $36,730	$36,731 - $45,913	$45,914 - $55,095	$55,096 - $64,278	$64,279 - $73,460	$73,461+
8	$0 - $40,890	$40,891 - $51,113	$51,114 - $61,335	$61,336 - $71,558	$71,559 - $81,780	$81,781+
For each additional person, add	$4,160	$5,200	$6,240	$7,280	$8,320	$8,320
Medical per visit rates	Nominal Fee of $35 per visit	Pay 20% of Charges per visit	Pay 40% of Charges per visit	Pay 60% of Charges per visit	Pay 80% of Charges per visit	Pay 100% of Charges per visit
Patients will be responsible for 100% of the discounted lab services						
Dental per visit rates	Nominal Fee of $70 per visit	Pay 20% of Charges per visit	Pay 40% of Charges per visit	Pay 60% of Charges per visit	Pay 80% of Charges per visit	Pay 100% of Charges per visit
Patients will be responsible for 100% of lab services and dental materials prepared off-site						

List ALL members of the Household by Name	Date of Birth	I am FINANCIALLY RESPONSIBLE for Y – YES N – NO	Patient at LWCHC Y - YES N - NO
		SELF	

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Patient Name_____Date of Birth___/___/___

Parent/Guardian Name_____

Release of Information

I, as legal guardian of the patient named above give permission for Live Well Community Health Center and Orrick School District to share medical and dental information.

Parent/Guardian Signature: _____

Dental Screening

I, (circle one) **do give / do not give** permission for the listed above patient to receive a dental examination provided by Live Well Community Health Center provided by a Licensed Dentist. The results of such examination will be forwarded to the parent/guardian. Sliding fee scale, if applicable, can be used for uninsured services if applicable for the dental examination and will be billed to the parent/guardian. Payment plans are accepted.

Parent/Guardian Signature: _____

Physical

I, (circle one) **do give / do not give** permission for the listed above patient to receive a Physical Examination by Live Well Community Health Center administered by a Licensed provider via tele-medicine. Sliding fee scale, if applicable, can be used for uninsured services for the medical examination and will be billed to the parent/guardian. Payment plans are accepted.

Parent/Guardian Signature: _____

Immunization

I, (circle one) **do give / do not give** permission for the Patient listed above to receive past due immunizations by Live Well Community Health Center as prescribed by a Licensed Nurse Practitioner. Immunizations that are excluded from this permission are: _____

Parent/Guardian Signature: _____

Behavioral Health

I, (circle one) **do give / do not give** permission for the listed above patient to receive a behavioral health service by Live Well Community Health Center administered by a Licensed Clinical Social Worker or psychiatrist. I understand that if Live Well Community Health Center does not complete the service, it will be up to myself and the Child Health Specialist to ensure its completion. Sliding fee scale, if applicable, can be used for uninsured services for the behavioral health examination and will be billed to the parent/guardian. Payment plans are accepted.

Parent/Guardian Signature: _____

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Transport for Treatment

I, (circle one) **do give / do not give** my consent for LWCHC/Orrick School staff/Community Health Worker to bring my child to Live Well Community Health Center for needed evaluation or treatment.

Parent/Guardian Signature: _____

Use of Information

I, (circle one) **do give / do not give** permission for my child's name and likeness (photo, video, electronic image) to be used in print or electronically published materials as distributed by the Live Well Community Health Center.

Parent/Guardian Signature: _____

The ability to perform these health services was formed through a partnership between Orrick School District and Live Well Community Health Centers. By dating this, I understand that services provided that qualify for insurance billing will be billed to applicable insurance companies. Sliding fee scale, if applicable, can be used for uninsured services for the medical/dental/behavioral health examination and will be billed to the parent/guardian. These fees will be billed to the child's parent/guardian. Payment plans are accepted.

I verify that this form was completed on ___/___/___.

PATIENT NAME: _____ DATE OF BIRTH _____/_____/_____

HEALTH HISTORY

	YES	NO
Have you been under the care of a physician in the past 2 years? If yes, pleas explain_____		
Have you been a patient in the hospital in the past 2 years? If yes, please explain_____		
Have you currently or have you in the past taken any Bisphosphonates drug (for Osteoporosis) to prevent bone loss? If yes, when was you last date medication was taken? _____/_____/_____		
Are you currently taking any blood thinners, like Coumadin?		
Do you have any bleeding problems?		
Do you smoke or use smokeless tobacco? Are you interest in quitting?		
Are you currently in or have you ever been in a substance abuse program?		
Have you used street drugs, IV drugs in the past 24 hours? If you please list all drug?_____		
Do you drink Alcohol beverages? How many do you normally consume daily? 1 -2 3 -4 or More		

MEDICATIONS LIST

We can make a copy if you have a list

_____

_____

_____

_____

ALLERGIES

	YES	NO
Are you allergic to any medications? Penicillin, Aspirin, Codeine Other: _____		
Are you allergic to latex (rubber)?		
Do you have any other allergies? If yes, please list _____		

WOMEN'S HEALTH

	YES	NO
Are you, or do you think you may be pregnant? If YES, when is your due date?_____/_____/_____		

Have you ever been diagnosed by a physician as having any of the following? **Please check all that apply**

- ○ Artificial Joints
- ○ Pacemaker, Stents
- ○ Anemia
- ○ Psychiatric Treatment
- ○ Kidney Problems
- ○ Constant Cough
- ○ Cancer _____
- ○ Heart Attack
- ○ Rheumatic Fever
- ○ High Cholesterol
- ○ Thrush / Oral Yeast
- ○ Chest Pains
- ○ Reflux Disease
- ○ Heart Murmur / Valve Problems
- ○ Tuberculosis
- ○ Stroke
- ○ Asthma
- ○ Pneumonia
- ○ Tuberculosis
- ○ Radiation
- ○ Arthritis
- ○ High Blood Pressure
- ○ Epilepsy
- ○ HIV
- ○ Hepatitis (A) (B) (C)
- ○ AIDS
- ○ Chemotherapy
- ○ Diabetes

DENTAL HISTORY

Why are you seeing a dentist today?
Please circle: Cleaning Toothache Sore Gums Sore Jaw Recent Jaw or Tooth Injury

When did you last see a dentist?

On a scale of 1-10, what is your current level of pain? **LOW** 0 1 2 3 4 5 6 7 8 9 10 **HIGH**

On a scale of 1-10 what is your level of anxiety? **LOW** 0 1 2 3 4 5 6 7 8 9 10 **HIGH**

	YES	NO
Does your child suck his or her thumb or fingers?		
Have you ever had abnormal or prolonged bleeding after a tooth extraction?		

_____ Patient /Parent/ Guardian Signature

_____ Reviewed by Dentist

Date____/____/____

LIVE WELL COMMUNITY HEALTH CENTERS

PARENT / GUARDIAN, PLEASE COMPLETE 1ST COLUMN ONLY

Today's Date: ______/______/______

Patient's Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: __________

Patient's Date of Birth _____/_____/_____ Grade: _____ Age: _______

Teacher's Name: ______________________________

Primary Phone #: ________________ Emergency #: ____________

Responsible Party / Parent / Guardian Name:

____

☐ No Allergies ☐ No Medical Alerts ☐ No Medications

Medications: ______________________________

____

Allergies: ______________________________

____

Medical Alerts: ______________________________

____

INSURANCE INFORMATION

Insurance Name: ______________________________

Medicaid DCN#:______________________________

S.S. #: of Insured: ________/________/________ DOB: ______________

Name of Insured: ______________________________

Employer: ______________________________

You have read & ensure that the above information is true and complete to the best of my knowledge. ________Initial

I understand that the medical/dental records may be shared by the above stated entities when necessary, on a need to know basis. ________Initial

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that LWCHC has made this available to me. ________Initial

DECLARATION OF NO INCOME (IF APPLYING FOR SLIDING SCALE)

I certify that I am currently unemployed and do not receive any income as of this date. I am receiving support from:

☐ Unemployment ☐ Friends / Family ☐ TDPA

☐ Energy Assistance ☐ Section 8 Housing ☐ TANF

☐ Food Stamps Other: ____________________

Please Read and Sign Below:

I request that the dentist perform dental check-up & x-rays as needed, as well as other dental work as needed. Including fillings, extraction of infected baby teeth, numbing the mouth and teeth. This permission includes future dental visits, I have read the IMPORTANT NOTICE AND CONSENT and understand and agree to its terms:

Signature: ______________________________ Date: ____/____/____

2ND COLUMN OFFICE USE ONLY

CAMPUS SITE: ____________________ DATE: ____________

DENTIST: ☐ DR. PETERSON ☐ DR. GEIGER

HYGIENIST : ☐ KYRA ☐ JAMI ☐ CAITLIN

****

☐ Exam Comp. ☐ Exam Established ☐ Exam Limited

☐ Oral Evaluation Under age 3

****

☐ Child Cleaning ☐ Adult Cleaning

☐ X-Rays #_____ BW # of _____P.A.

☐ Fluoride

☐ URGENT CARE NEEDED ☐ Can be treated on site

☐ No Treatment Needed ☐ In Clinic Treatment Needed

☐ NITROUS

TREATMENT PLAN

#	SURFACE	T/P	TREATED ON SITE	EXISTING	REFERRAL
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
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		☐	☐	☐	☐
		☐	☐	☐	☐

TREATMENT NOTES:

O/H – BRUSHING: ☐ POOR ☐ GOOD ☐ EXCELLENT

____

____

____

____

____

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PATIENT REGISTRATION FORM

Today's Date: _____

Patient information: (Please use full legal name)

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____ Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Cell Phone #: _____

Social Security #: _____

May we contact you by: (please circle all that apply) Primary phone Work phone Email Text Message Other

Date of Birth: _____ Age: _____ Sex: M – F Transgender

Marital Status: Single Married Divorced Widow Legally Separated Partner

Emergency Contact Name: _____ Emer. Cont. Phone #: _____

Emergency Contact Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Mail-In Pharmacy: _____ Phone: _____

The following information is requested by the Federal government in order to monitor compliance with Federal laws prohibiting discrimination against users of Live Well Community Health Centers (LWCHC – all locations). You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in aggregate form.

(Please circle all that apply)

Race: Asian Black-African-American Native American Pacific Islander Hispanic White Other _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Other _____ Decline _____

Do you have hearing/language difficulties? YES NO (If yes, how can we better serve you?)

_____

Primary Language: English Spanish Other _____

Are you a Veteran? YES NO

Housing Status: Homeless Public/Temporary Housing Doubling up with Family or Friends Shelter Street Own/Rent

Do you have reliable transportation? YES NO

Have you or a Family Member used public transportation in the past 6 months? YES NO OATS WILS Other
Have you been to ER or been in the hospital since your last visit? YES NO Is this a referral from ER? YES NO
Would you like to be contacted about medical coverage? YES NO
Do you have an Advanced Directive? YES NO

EMPLOYMENT INFORMATION (For Patient)

Employment Status: Full-Time Part-Time Student Unemployed Retired Disabled

Are you a Migrant or Seasonal Worker? YES NO Circle One: Migrant Seasonal

Employer Name and Address: _____

Work Phone: _____

RESPONSIBLE PARTY INFORMATION: (List person or insured name responsible for bill - use full legal name)

Relationship of Responsible Party to Patient: Self Spouse Parent Other

Last Name: _____ First Name: _____ Middle Initial: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: M F

Employer Name and Address: _____

Work Phone #: _____

INSURANCE INFORMATION: (please allow Front desk staff to photocopy your insurance cards and photo ID)

Relationship of Insured to Patient: Self Spouse Parent Other

IF SOMEONE OTHER THAN THE PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Co-pay Info: _____

Plan Name: _____

Insured's Name: _____

Insured's Social Security#: _____

Insured's Date of Birth: _____

Policy/ID #: _____ Group #: _____

Effective Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Co-pay Info: _____

Plan Name: _____

Insured's Name: _____

Insured's Social Security #: _____

Insured's Date of Birth: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claims Address & Phone: _____

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

AUTHORIZATION FOR SHARED MEDICAL RECORD CONSENT WITHIN LWCHC

I understand that my medical dental and behavioral health records, will be shared by the above stated entities when medically necessary, on a need to know basis. _____ Initial

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that LWCHC has made available to me the HIPAA NOTICE OF PRIVACY PRACTICES. _____ Initial

AUTHORIZATION TO PROVIDE MEDICAL & HEALTH CARE SERVICES

I hereby authorize LWCHC to provide medical examination services, immunological services, and routine medical/health services as considered normal and necessary; to secure and consent to medical, surgical, dental, and psychiatric care that is deemed necessary by a licensed physician, nurse, or mental health provider. _____ Initial

NOTE: These authorizations are to be filled out and initialed by a parent, legal guardian or person representing legal custody prior to the child being treated by our providers. The policy of LWCHC in all instances of needed surgical or other medical care requiring hospitalization is to secure in advance the proper specific authorization from parent (s), guardian or legal custodian thereafter.

ASSIGNMENT OF INSURANCE-MEDICARE/MEDICAID/ MEDIGAP BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby authorize payment directly to Live Well Community Health Centers for the medical and/or surgical benefits for any services furnished to me or my dependents. I hereby authorize LWCHC to release any information acquired in the course of my examination or treatment necessary to establish a health insurance claim payment. I understand that occasionally my insurance company will deny payment for services that my physician and/or I feel necessary for my good health. Please note that self-pay/sliding scale patients may incur additional charges outside of self-pay office visit fees. I agree to pay for such services in a prompt and timely manner. I hereby authorize LWCHC providers to prescribe treatment, administer medications, and perform such procedures and tests that may be deemed advisable or necessary in the diagnosis of me or my dependents. I authorize LWCHC to release information to: (Please check all apply)

_____ Initial

_____ Spouse

_____ Children (Names)

_____ Other _____

APPOINTMENT POLICY

LWCHC requires at least 24 hours' notice from patients who need to cancel or reschedule an appointment. A patient is considered a "No Show" if they are 15 minutes late for their scheduled appointment. It is decided at the discretion of the Director of Operations as to whether the patient is to be rescheduled or if they are to be worked into the schedule. Because of the high demand for after-school appointments (at or after 3:00PM), if a member of my family has a "missed, broken appointment or no show", I may no longer be able to schedule after-school appointments for my family members. As a patient of the clinic, I and my dependent's agree to: 1. Arrive early or on time to all scheduled appointments; 2. I hereby agree that if I "no show" for 3 visits within 6 months, I will be asked to seek medical services elsewhere; 3. Keep the clinic informed of changes to my contact information, especially a working telephone. If I do not show up for an appointment, I will have a "missed appointment." If I do not give at least 24 hours to cancel or reschedule an appointment or if I am asked to reschedule because I arrive late, I will have a "broken appointment." **It is the policy of LWCHC that if a behavioral health, primary care, or dental patient misses 3 appointments within a 6 month period their patient status may be terminated.**

I certify that I have read, completed and ensure that the information I provided is true and complete to the best of my knowledge. In addition, I have submitted verification of ALL household income sources in order for this application to be processed for financial screening, if necessary. I understand completion of this form does not guarantee a discount, and if I do not qualify for the Sliding-Fee Scale, I agree to pay in full or set up a payment plan. If my financial status changes, I agree to inform the LWCHC with current documentation of my financial status at my next visit. I also agree to be re-evaluated annually by providing updated income verification. In addition, **I understand that if I qualify for the Sliding-Fee Scale, I must pay a minimum payment of $35 per appointment (medical and behavioral health), I must pay a minimum payment of $70 per appointment (dental).**

PATIENT SIGNATURE: _____ DATE: _____

RESPONISIBLE PARTY SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY NAME (please print): _____

I GIVE PERMISSION FOR: _____ TO BRING MY MINOR CHILD(REN) TO BE SEEN IN CASE I AM UNABLE TO BRING THEM MYSELF.

Are you interested in a SLIDING-FEE SCALE option? YES NO (If yes, requires proof of income)

Please provide a copy of the following:

- Your most recent income tax return
- Forms W-2 or Forms 1099 received by the household
- Payroll stubs for the last 30 days
- Forms from Medicaid or state funded programs
- Forms from employers or welfare agencies
- Any other proof of income received in the last 30 days

☐ **I decline to provide my income information and understand that this declination makes me ineligible for any slide fee discounts.**

Please complete the information in the following table based on average income and expenses over the last 12 months. For amounts paid annually, enter annual amount divided by 12.

Household financial information

Gross Monthly Income		**Monthly expenses**	
Employment	$	Mortgage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tools)	$
Interest/dividends	$	Insurance (life, homeowners, health)	$
Pension/disability	$	Utilities (electric, water, gas)	$
Child support/alimony	$	Medications (out of pocket costs)	$

DECLARATION OF NO INCOME **(only complete if applying for Sliding-Fee scale and you have no income)**

I certify that I am currently unemployed and do not receive an income as of this date. However, I have been receiving support beginning _____ from the following resources: (please circle all that apply)

Relatives/Friends Energy Assistance Section 8 Housing Unemployment/Unemployment Pending

TDPA Food Stamps TANF

Signature of Applicant_____ Date: _____

Printed Name of Applicant_____

List ALL members of the Household by Name	Date of Birth	I am FINANCIALLY RESPONSIBLE for Y – YES N – NO	Patient at LWCHC Y - YES N - NO
		SELF	

As a recipient of Federal financial assistance, the Health Care Collaborative of Rural Missouri and its clinics: Live Well Community Health Center – Waverly, Concordia, Buckner & Carrollton, do not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by the Health Care Collaborative of Rural Missouri and its clinics: Live Well Community Health Center – Waverly, Concordia, Buckner & Carrollton, directly or through a contractor or any other entity with which the Health Care Collaborative of Rural Missouri and its clinics: Live Well Community Health Center – Waverly, Concordia, Buckner & Carrollton, arranges to carry out its programs and activities.

Health Care Coalition of Lafayette County						
dba/ Livewell Community Health Centers						
Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Based upon 2016 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)						
Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Slide A	Slide B	Slide C	Slide D	Slide E	Full Pay
1	$0 - $11,880	$11,881 - $14,850	$14,851 - $17,820	$17,821 - $20,790	$20,791 - $23,760	$23,761+
2	$0 - $16,020	$16,021 - $20,025	$20,026 - $24,030	$24,031 - $28,035	$28,036 - $32,040	$32,041+
3	$0 - $20,160	$20,161 - $25,200	$25,201 - $30,240	$30,241 - $35,280	$35,281 - $40,320	$40,321+
4	$0 - $24,300	$24,301 - $30,375	$30,376 - $36,450	$36,451 - $42,525	$42,526 - $48,600	$48.601+
5	$0 - $28,440	$28,441 - $35,500	$35,501 - $42,660	$42,661 - $49,770	$49,771 - $56,880	$56,881+
6	$0 - $32,580	$32,581 - $40,625	$40,626 - $48,870	$48,871 - $57,015	$57,016 - $65,160	$65,161+
7	$0 - $36,730	$36,731 - $45,913	$45,914 - $55,095	$55,096 - $64,278	$64,279 - $73,460	$73,461+
8	$0 - $40,890	$40,891 - $51,113	$51,114 - $61,335	$61,336 - $71,558	$71,559 - $81,780	$81,781+
For each additional person, add	$4,160	$5,200	$6,240	$7,280	$8,320	$8,320
Medical per visit rates	Nominal Fee of $35 per visit	Pay greater of 20% of Charges per visit or nominal fee	Pay greater of 40% of Charges per visit or nominal fee	Pay greater of 60% of Charges per visit or nominal fee	Pay greater of 80% of Charges per visit or nominal fee	Pay greater of 100% of Charges per visit or nominal fee
Patients will be responsible for 100% of the discounted lab services						
Dental per visit rates	Nominal Fee of $70 per visit	Pay greater of 20% of Charges per visit or nominal fee	Pay greater of 40% of Charges per visit or nominal fee	Pay greater of 60% of Charges per visit or nominal fee	Pay greater of 80% of Charges per visit or nominal fee	Pay greater of 100% of Charges per visit or nominal fee
Patients will be responsible for 100% of lab services and dental materials prepared off-site						

OFFICE USE ONLY

Financial Screening Outcome: _____ **Ineligible** _____ **Eligible** (circle discount level) **A B C D E F**

Financial Screening Preformed By: _____ Date: _____

Type of Documentation that is ACCEPTABLE for Income Verification

Income Type	Amount				Proof Provided
Wages/Tips (W2, Tax Return, Letter from Employer, Pay Stub)	_____	W	M	Y	_____
Unemployment or Letter from Unemployment office Stating Benefit	_____	W	M	Y	_____
Copy of Child support Check or Letter/Support of Alimony	_____	W	M	Y	_____
Copy of Pension, Annuities, Retirement, or Disability Benefits	_____	W	M	Y	_____
Military Allotments or Veterans Benefits	_____	W	M	Y	_____
Estate or Trust Income	_____	W	M	Y	_____
Interests, Dividends, or Royalties	_____	W	M	Y	_____
Income from Training	_____	W	M	Y	_____
Income from Rent	_____	W	M	Y	_____
Farming/Gardening Income	_____	W	M	Y	_____
Babysitting, Lawn Service	_____	W	M	Y	_____
Help from Family/Friends	_____	W	M	Y	_____
Other Types of Income	_____	W	M	Y	_____
Notification or Award letter from Another agency providing Benefit	_____	W	M	Y	_____
	_____	W	M	Y	_____

TOTAL: _____

Do Not Complete – For Office Personnel Use Only

Estimated Treatment Planned Amount: $_____

Estimated Lab Fee Amount: $_____

☐ Approved for the amount of $_____ Expires on _____/_____/_____

☐ Denied / Reason for denial _____

Approved by: _____ Title: _____