SMC Oral Health Task Force: Assistance Application

Applicant's Name_____ Date of Birth _____

Spouse's Name _____ Date of Birth _____

Address_____

Home _____ Cell _____ Work _____

Spouse's Work _____ Email _____

Family members(18 months to 26 years of age, or 65 years or older)

First Name	Birth Date	Last Name if Different

(Attach separate sheet if more space is needed)

Circle the option that best describes your situation. I have:

Dental insurance Medical insurance Both Neither

If you have dental insurance, please list your insurance carrier: _____

Group #_____ Policy _____

SMC Oral Health Task Force – Assistance Program Income Caps:

Family Size	Income Eligibility Cap
1	$69,851+
2	$94,150+
3	$118,449+
4	$142,748+
5	$167,046+
6	$191,346+
7	$215,645+
8	$239,944+

If you or your family falls within the above eligibility parameters, your family will pay 10% of the charges.
If you are 65 years old or older, there is a maximum of $800 per person coverage.

(Please turn over)

If you are uninsured or struggle to afford your health and dental care, you may be eligible for Sawtooth Mountain Clinic's Sliding Fee Scale Program or for Medical Assistance. Please call Karen at Sawtooth Mountain Clinic (218 387-2330) to learn more about these programs and how to apply.

SMC Sliding Scale Fee Scale Program Income Caps:

Family Size	Level A	Level B	Level C	Level D
1	$0 – 12,880	$12,881 – 17,173	$17,174 – 21,467	$21,468 – 25,760
2	$0 – 17,420	$17,421 – 23,337	$23,338 – 29,033	$29,034 – 34,840
3	$0 – 21,960	$21,961 – 29,280	$29,281 – 36,600	$36,601 – 43,920
4	$0 – 26,500	$26,501 – 35,333	$35,344 – 44,167	$44,168 – 53,000
5	$0 – 31,040	$31,041 – 41,387	$41,388 – 51,733	$51,734 – 62,080
6	$0 – 35,580	$35,581 – 47,440	$47,441 – 59,300	$59,301 – 71,160
7	$0 – 40,120	$40,121 – 53,493	$53,494 – 66,867	$66,868 – 80,240
8	$0 – 44,660	$44,661 – 59,547	$59,548 – 74,433	$74,434 – 89,320

Are you eligible for the Sawtooth Mountain Clinic Sliding Fee Scale Program? Yes No

If so, an application needs to be filled out along with financial verification. The clinic becomes the primary health care provider and Oral Health Task Force becomes the secondary provider.
Any outstanding balance due will be billed to the patient by Sawtooth Mountain Clinic.

Family income for past 12 months from all jobs: _____*

*Attach proof of income i.e. latest Federal Income Tax Statement 1040 showing your adjusted gross income which is usually on the first page, or your W2.

You must be a registered patient at Sawtooth Mountain Clinic in order to be covered by the Oral Health Task Force or SMC's Sliding Fee Scale Program . Are you a patient at SMC? Yes No

Please return this application and proof of income by _____. If these are not returned to Grand Marais Family Dentistry by the aforementioned date, I understand that I will not be enrolled in the Oral Health Task Force program and I will be responsible for 100% of my balance.

I hereby acknowledge that I have read these instructions: The Oral Health Task Force, Grand Marais Family Dentistry and the Sawtooth Mountain Clinic may share my income information to determine program availability. I understand that the Oral Health Task Force's assistance is a defined program with service and payment limits. The Task Force will not be responsible for bills which I may incur outside of the specified limits. I hereby swear that the above information is correct as stated. Falsifying this information is a crime punishable by law.

_____ _____ _____

Signature Spouse's Signature Date