

SARANAC LAKE VOLUNTARY HEALTH ASSOCIATION, INC.

81 MAIN STREET, SUITE 3

SARANAC LAKE, NY 12983

518-891-0910

Request for Dental Assistance

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Applicant if Patient is a Minor: \_\_\_\_\_

Present Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Home Telephone No.: \_\_\_\_\_ Work Telephone No.: \_\_\_\_\_ Cell Telephone No.: \_\_\_\_\_

School District of Residence: \_\_\_\_\_ Referred by: \_\_\_\_\_

Does Patient Receive Medicaid Assistance, Family Health Plus or have Dental Insurance Policy?  Yes  No  
If Yes, What Is Your Coverage?

Does Patient's Health Insurance include any dental benefit?  Yes  No  Uncertain

If Yes, What is Your Coverage? (annual amount, services covered, claim submission procedure, etc)

**If No or Uncertain, please verify with your Health Insurance Customer Service:**

Name of Health Insurer \_\_\_\_\_ Phone Number \_\_\_\_\_ Date contacted \_\_\_\_\_

Explanation of dental benefit: (annual amount, services covered, claim submission procedure, etc.)

**Please submit photocopy of both front and back of ALL health insurance cards.**

Total Number of People Living in Patient's Household \_\_\_\_\_

**Monthly Total Gross Income of All Household Members:**

Wages and Salaries (after withholding taxes)	\$ _____
Interest and Dividends	\$ _____
Pension Income, Rental Income, Unemployment, Workers' Compensation	\$ _____
Child Support, Spousal Maintenance	\$ _____
Other Income Including Food Stamps, Social Service Benefits, Social Security, Disability, etc.	\$ _____
Other Income (please explain below)	\$ _____
<b>Total Monthly Gross Income</b>	<b>\$ _____</b>

**Monthly Expenses and Disbursements:**

Rent/Mortgage payment	\$ _____
Real Estate Taxes	\$ _____
Utilities, Phone, Insurances	\$ _____
Loans, Credit Cards	\$ _____
Child Support and/or Spousal Maintenance	\$ _____
Food	\$ _____
Other (please explain below)	\$ _____
<b>Total Monthly Expenses</b>	<b>\$ _____</b>

**Please include 2 most current, different paystubs for each person employed and/or other income verification documents**

Income Explanation/Comments: \_\_\_\_\_

Expense and Disbursements Explanation/Comments: \_\_\_\_\_

Is There a Specific Reason You Need to See a Dentist? (please explain) \_\_\_\_\_

Name of Dentist _____	Total Cost of Procedure	\$ _____
	Contribution by Dentist	- \$ _____
	Adjusted Total Cost of Procedure	\$ _____
	Contribution by Patient	- \$ _____
	Amount Requested from SLVHA	\$ _____

Comments by Patient (if any): \_\_\_\_\_

I affirm that the above statements are true and accurate. I consent that the patient dental records can be released to SLVHA if requested.

\_\_\_\_\_  
Patient Signature (parent or guardian if patient is a minor)      Date

**FOR OFFICE USE ONLY**

