Dear Patient,

Our records indicate that you were seen by a provider of The Wright Center for Community Health and you did not have any dental insurance coverage for the services provided.

If you have dental coverage, please call the Jermyn Dental Department at 570-230-0019 or the Scranton Dental Office at 570-941-0630 with your insurance information and we will update your file and submit these charges.

If you do not have dental coverage or have a balance after submission to your insurance that you are unable to pay, you may qualify for the Sliding Fee Discount Program (SFDP). Eligibility is based on self reporting of family income and size. To determine your eligibility, please complete the enclosed application. All proof of all income, for each member of your household, will be required for this step. Examples of acceptable proofs of income are listed below, not all may be applicable:

- W-2 Form or most recent pay stubs from the last month of employment
- Current tax return
- Unemployment, Social security, Disability, Workers' Compensation award letter
- Child support and/or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Letter from person/persons supplying support showing amount and frequency of support

Please send your application to:

The Wright Center for Community Health
501 South Washington Avenue, Suite 1000
Scranton, PA 18505
Attention: Outreach and Enrollment Coordinator/Navigator

You may contact me at 570-591-5253 with any questions.

Thank you for your prompt response.

Desiree Natale
Outreach and Enrollment Coordinator/Navigator

APPLICATION FOR DENTAL SLIDING FEE DISCOUNT

Patient Name: _____ Date of Request: _____
Last First Middle Date of Appointment: _____

Address: _____

_____
City State Zip Code

Phone Number: (cell) _____ (home) _____

Number of household members living at the above address _____

Family/Household members: The number of persons living in the household, who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that other persons may reside at the common residence and not be considered as part of the household unit.

(Any person, including yourself, living in household must be listed below):

Name Date of birth

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

HOUSEHOLD INCOME (List ALL household income for all adult household members):

	Total for 12 months
Gross Wages, Salaries, Tips	$_____
Social Security	$_____
Disability	$_____
Farm/Self-Employment Net Earnings	$_____
Unemployment	$_____
Public Assistance (exclude food stamps)	$_____
Workers' Compensation	$_____
Alimony	$_____

Child Support	$_____
Military	$_____
VA Benefits	$_____
Pensions/Annuities	$_____
Dividend or Interest Income	$_____
Rental Income	$_____
Total	$_____

PROOF OF INCOME IS REQUIRED FOR EACH ADULT MEMBER OF HOUSEHOLD.

Examples of acceptable proof of income are:

- W-2 Form, 2 current pay stubs
- Current tax return
- Unemployment, Social security, Disability, Workers' Compensation award letter
- Child support and/or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Letter from person/persons supplying support showing amount and frequency of support

Does patient currently have any medical insurance? Yes_____ No _____
If yes, please complete the following information: (medical)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name: _____Date of Birth: _____

Does patient currently have any dental insurance? Yes_____ No _____
If yes, please complete the following information: (dental)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name: _____Date of Birth: _____

Occupation of Patient: _____

Employer Name: _____

Employer Address: _____

If you had a change in financial circumstance since your last application, please provide documentation of current income or financial status and write a note explaining how it has changed.

_____
_____
_____

I affirm that the above information is true and correct.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

For Office Use Only

This document was received on _____By _____

Rate approved per table_____ Reapply by _____