

SARANAC LAKE VOLUNTARY HEALTH ASSOCIATION, INC.

75 MAIN STREET, SUITE 2

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 Coverage? Yes No
If Yes, What Is Your Coverage?

Total Number of People Living in Patient's Household _____

Monthly Total Gross Income of All Household Members:

Monthly Expenses and Disbursements:

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

Rent/Mortgage payment \$ _____
 Real Estate Taxes \$ _____
 Utilities, Insurances \$ _____
 Loans, Credit Cards \$ _____
 Child Support, Alimony,
 Maintenance, etc. \$ _____
 Food \$ _____
 Other (please explain below) \$ _____
Total Monthly Expenses \$ _____

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

Notes: **SEE BACK -->**

Approved \$ _____

by: _____

DECAF Member/Board Member Date

Denied by: _____

DECAF Member/Board Member Date

by: _____

DECAF Member/Board Member Date

Denied by: _____

DECAF Member/Board Member Date

Reason for Denial:

