West Kootenay Community TEETH Clinic Application

NOTICE: The information provided will be held in strictest confidence and not shared, except as it may be necessary in regards to medical information, medical emergency, treatment and records.

Name: _____ _____ _____ M/F/other _____ DOB_____
(First) (Last) (mm/dd/yyyy)

Residency:
Proof of 3 months in Kootenay Boundary: yes _____

Do you have dental insurance? yes ____ no ___

If yes, Company Name _____ Policy No. _____ ID _____

Financial:
Do you receive any form of income support? yes_____no_____ **If yes, from whom** _____

Is your family income less than $42,000? yes____no_____

Do you identify as aboriginal? yes_____no_____If yes, Status # _____

Address_____City_____Postal Code _____

Personal Health No_____ Email _____

Please put the letter **E** in space behind the last name above, if dental pain or infection,
D if a denture is needed and **M** if on medication. Clients need to bring a list of their medications to their appointment.

Can you do short notice appointment?_____How much notice is needed? _____

Phone_____ _____ _____
Home Cell Work

I declare the above information is correct and accurately reflects my financial and residency situation**. I am aware this is not a free service and I am responsible for dental services costs at the time of treatment.** This information has been freely provided and the notice understood as indicated by my signature.

Date____/____/____ Signature of Applicant_____
mm/dd/yy

(for verifier only): List the types of proof submitted_____

_____

_____

_____ _____ _____
Print Verifier's Name **Verifier's Signature** **Date**

Please see pamphlet for verification locations.

Email: all verified forms to teethclinicwk@gmail.com Or mail to TEETH Clinic, 632 Front St. Nelson, BC. V1L 4B7 (250.352.3543).To register additional family members, please complete page 2 as well.

West Kootenay Community TEETH Clinic – Only to be completed and submitted if there are additional family members.

Please provide names, birthdates & **P**ersonal **H**ealth **N**umber's (**PHN**) of additional family members applying to attend the clinic.

Please put the letter **E** next to a client's name if they have dental pain or infection, **D** if they need a denture and **M** if on medication. Please bring a list of the medications to your appointment.

Please Print clearly in Black Ink.

Applicant's Name: _____

	(First and Last Name)	M/F/other	Birthdate	Personal Health #
____Spouse	_____	____	__/__/__	_____
Dependents/Children				
____Oldest	_____	____	__/__/__	_____
____Next	_____	____	__/__/__	_____
____Next	_____	____	__/__/__	_____
____Next	_____	____	__/__/__	_____

Only To be completed for Individuals requiring The Adjusted Income Process.

Please fill out sections A, C & D if you are supplying your notice of tax assessment as proof of income. Please fill out B C & D if you do not have a current Tax notice of assessment.
(Section E is for office use only)

SECTION A: Net Family Income	
This information is from my income tax return for the tax year:	
Enter net income	$_____(1)
Enter net income of your spouse or common-law partner	$_____(2)
Total Net Income (add lines 1 & 2)	**$_____(3)**

SECTION B:	
Enter your monthly income x 12	$_____(A)
Enter your spouse's or common-law partner's monthly income X 12	$_____(B)
Total Net Income (add lines A, B)	**$_____(AB)**

SECTION C: Answer following questions appropriately.	**SECTION E** (for office use: lines 4 through 6 have a "**yes**" value of $3,000.)

Do you have a spouse, or are you living common-law?	Yes__No___	$_____(4)
Are you 65 or older this year?	Yes__No___	$_____(5)
Is your spouse or common-law partner 65 or older?	Yes__No___	$_____(6)
How many children under the age of 18, are living with you ?_____x $3,000	Yes__No___	$_____(7)
Are you, or anyone in your family disabled? number _____ x $3,000 =	Yes__No___	$_____(8)
Total deductions (add lines 4 to 8)		$_____(9)
SECTION D:		
Adjusted Net Income (subtract line 9 from line 3 or line A,B,C)		**$_____(10)**

I declare the information that I have provided for my income and deductions is correct and accurately reflects my financial situation.

_____ _____Date_____
Signature of applicant Print name

(note income needs to be verified on page one of form)

If Adjusted Net Income from line (10) above exceeds $42,000. but there are extra-ordinary expenses please complete page 4.
Financial Disclosure Worksheet for Applicants with more than $42,000, net family income but with significant extra-ordinary expenses.

Applicants require extra expenses to bring the income below $42,000 cannot be approve by the verifiers, this page must be approved by the Operations Committee.

TOTAL ADJUSTED NET INCOME FROM LINE 10 (page 3)	$_____
Extra-ordinary Expenses: (List all categories & annual amounts paid)	
	$_____
	$_____
	$_____
	$_____
	$_____
	$_____
TOTAL Expenses	$_____
Total adjusted net income (from above) less TOTAL Expenses	$_____

I declare the above information is correct and accurately reflects my additional extra-ordinary expenses.

Date_____ Signature of applicant: _____

Print name: _____

* For the application committee to consider approval of this application the Adjusted Net Income less Total extra-ordinary expenses must be less than $42,000.00 annually.

Completion of this application and this worksheet does not guarantee approval for dental treatment. Applicant will be contacted by the clinic approval committee unless approved by the interviewer.

If this page is needed, please, put an alert on the communication.