



Sliding Fee Discount Application

It is the policy of Willamette Dental (WD) to provide essential primary care services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk or email to memberservices@willamettedental.com to determine if you or any members of your family are eligible for a discount.

The discount applies to all Sliding Fee Discount Program (SFDP) covered primary care services received at participating WD locations or through referrals made by dentists at those locations. The discount will not apply to any service or equipment not deemed a SFDP covered primary care service, regardless of WD participating location providers' recommendation. This form must be completed at least once every 12 months or any time your financial situation changes.

| Name of head of household | | Place of employment | | |
|---------------------------|------|---------------------|-----|-------|
| | | | | |
| Street | City | State | Zip | Phone |
| | | | | |

Please list spouse and dependents under the age of 18.

| Name | Date of birth | Name | Date of birth |
|-----------|---------------|-----------|---------------|
| Self | | Dependent | |
| Spouse | | Dependent | |
| Dependent | | Dependent | |
| Dependent | | Dependent | |

If applicable, list any active dental insurance information:

| Carrier Name & Phone #: | Subscriber Name | Subscriber Date of Birth | Subscriber # | Group # |
|-------------------------|-----------------|--------------------------|--------------|---------|
| | | | | |

Annual Household Income

| Source | Self | Spouse | Other | Total |
|---|------|--------|-------|-------|
| Gross wages, salaries, tips, etc. | | | | |
| Income from business, self-employment, and dependents | | | | |



| | | | | |
|---|--|--|--|--|
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income | | | | |
| Interest, dividends, rents, royalties, incomes from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources | | | | |
| Total Income | | | | |

NOTE: Copies of tax returns, pay stubs, or verifying information (listed above) is required before a discount can be approved. A copy of your driver's license or an employment ID must also be included with the application.

I certify that the family size and income information shown above is correct.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

| Verification checklist | Yes | No |
|---|-----|----|
| Identification/address: Driver's license, utility bill, employment ID, or other | | |
| Income: Prior year tax return, two most recent pay stubs, or other | | |
| Insurance: Insurance cards | | |