Dental Clinic Eligibility Application

- ***Before completing this application, have you applied for Virginia Medicaid? <u>You may be eligible!</u> To apply, visit: www.coverva.org or call 1-855-242-8282. You may also contact your local Department of Social Services for more information or for assistance in applying. If you have applied and have been found ineligible, please continue with this application.***

- **If you have current Financial Assistance approved by Augusta Health, please stop filling out this form and call the Dental Clinic at 540-221-6635.**

- **Attach a copy of your paycheck stubs (and your spouse or domestic partner's) for the most recent month**
  - If you do not have traditional paystubs you must have your employer write a letter verifying wages and hours for the past month
  - If you have NO income you must have a "Letter of Support" completed by the person who is financially supporting you

- **Attach a copy of your most recent tax return**
  - If you did not file taxes this year, please indicate so on the application form

- **Mail all information to the Augusta Regional Dental Clinic P.O. Box 153, Fishersville VA, 22939**
  - You may also bring completed application directly to clinic and place in outdoor drop box located near the front door

- **Your application will be processed and a determination letter will be mailed to the address on the application**

- **Approvals are effective for a period of one year**

- **All dental appointments must be paid for in advance**

- **Any families with income above 300% of the Federal Poverty Guidelines will not be eligible for dental services at Augusta Regional Dental Clinic**

Household Size	0- 250% $45 co-pay	251-300% $75 co-pay
1	$31,900	$38,280
2	$43,100	$51,720
3	$54,300	$65,160
4	$65,500	$78,600
5	$76,700	$92,040
6	$87,900	$105,480
7	$99,100	$118,920
8	$110,300	$132,360

DENTAL CLINIC
ELIGIBILITY APPLICATION

Do not leave any fields blank. If it is not applicable to you, write N/A. Incomplete applications will *not* be processed.

Applicant's Information

Applicant's Full Name _____
Date of Birth _____ Gender _____ Ethnicity _____
Street Address _____
City, State, Zip Code_____
Phone Number _____

Marital Status:
[ ] Single [ ] Married [ ] Divorced [ ] Widowed

Employment Status:
[ ] Full-time [ ] Part-time [ ] Self- Employed [ ] Unemployed [ ] Student

Employer's Name _____
Phone Number _____

Do you have dental insurance?
[ ] Yes [ ] No

If yes, what type?
[ ] Medicaid [ ] Private Insurance (Delta, Aetna, Cigna, Anthem, etc)

Are you applying to become an Augusta Regional Dental Clinic patient due to recent loss of Medicaid coverage?
[ ] Yes [ ] No

Do you have Medicare? [ ] Part A [ ] Part B [ ] No

Did you file taxes last year?
[ ] Yes [ ] No

Spouse or Domestic Partner's Information

(If you do not have a spouse or domestic partner you do not need to complete this portion)

Spouse or Domestic Partner's Full Name_____
Date of Birth _____
Street Address _____
City, State, Zip Code_____
Phone Number _____
Gender _____ Ethnicity _____

Spouse or Domestic Partner's Employment Status:
[ ] Full-time [ ] Part-time [ ] Self- Employed [ ] Unemployed [ ] Student

Employer's Name _____
Phone Number _____

Does Spouse or Domestic Partner have dental insurance?
[ ] Yes [ ] No

If yes, what type? [ ] Medicaid [ ] Private Insurance (Delta, Aetna, Cigna, Anthem, etc)
Are you applying to become an Augusta Regional Dental Clinic patient due to recent loss of Medicaid coverage?
[ ] Yes [ ] No

Do you have Medicare? [ ] Part A [ ] Part B [ ] No

Did you file taxes last year? [ ] Yes [ ] No

Dependent Information (List all those under your legal guardianship ***living with you***)

Dependent's Name	Date of Birth	Relationship	Name of Dental Insurance (if any)

INCOME INFORMATION

IF YOU HAVE NO SOURCE OF INCOME PLEASE COMPLETE A "LETTER OF SUPPORT" TO BE COMPLETED BY THE PERSON WHO IS SUPPORTING YOU AT THIS TIME.

Applicant's Source of Income

(Complete all that apply and ***provide documentation*** for each applicable item below)

Indicate all sources of income you receive	How often do you receive it?			Gross Amount
Wages or Self-Employment Income	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Social Security Income	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Retirement/Pension	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Alimony or Child Support	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Unemployment Benefits	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$

Spouse or Domestic Partner's Source of Income

(Complete all that apply and ***provide documentation*** for each applicable item below)

Indicate all sources of income you receive	**How often do you receive it?**			**Gross Amount**
Wages or Self-Employment Income	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Social Security Income	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Retirement/Pension	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Alimony or Child Support	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$
Unemployment Benefits	Weekly [ ]	Bi-Weekly[ ]	Monthly [ ]	$

Acknowledgment

I acknowledge that the information provided is true and accurate to the very best of my knowledge. I understand that if any information is found to be false that this application will be denied. By signing below, I authorize Augusta Regional Dental Clinic to verify information provided in this application with listed employers or other listed agencies. I understand that I may be asked to provide more information. I understand that a letter of determination will be mailed to the address provided on this form in a timely manner.

ARDC does not discriminate based on race, color, national origin, religion, sex, gender identity, (including gender expression) sexual orientation, disability, age, marital status, family/parental status, income derived from public assistance programs, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program of activity funded by USDA Rural Development.

Applicant's Signature _____
Date _____

Spouse or Domestic Partner's Signature _____
Date _____