Chart Number __________
(for internal use only)

2020
Lindquist Dental Clinic for Children

Parkland * Bremerton

Financial Assistance Application

LDCC is a private not-for-profit dental clinic and we work very hard to ensure that we fulfill our mission to “provide accessible, compassionate and effective dental care to Puget Sound children in need.” A critical part of fulfilling our mission is to offer “Financial Assistance” to those who are underinsured or have no insurance. Although LDCC “turns no child away due to inability to pay” we are **NOT** a “free clinic.”

The determination of a family’s “ability to pay” and the amount of financial assistance that your family **may** qualify for is based on your family size and gross household income (not how many other bills you have). Based on these factors, your family may qualify for financial assistance and the dental services provided to your child/ children would be put on a sliding fee scale with the expectation that you will pay your portion of this financial agreement.

As much as we wish we did not have to charge anybody for services, in order for us to continue to provide dental care for children in need in our community, families must adhere to their percentage of payment for services received.

Date: ______________________________

Parent/Guardian’s Name____

Parent/Guardian’s Phone ( ) — ( ) — ( ) —
Mobile Home Work

Head of Household is: ____Male ____ Female Military?: ____Active ____ Retired ____ Reserve

Family’s Racial/Ethnic Background (If you associate with more than one race/ethnicity, please check all that apply)

____Caucasian ____ African American ____ Hispanic/Latino ____ Asian

____ Eastern European ____ Native Hawaiian/Pacific Islander ____ Multi-Racial ____ Other ______________

Income Statement

Please provide proof of income for the household as a paystubs or pay statements for all parental/guardian income. If more than one job, or if more than one parent/guardian is working, proof of income is needed for all income and/or both parental/guardian income.

Frequency	2 x month	Every 2 wks	1 x month	Weekly	Other
Proof #1					
Proof #2					
Proof #3					
Proof #4					
Proof #5					
Total					
Multiplier	24	26	12	52	
Subtotal					

Grand Total Annual Income: ______________________ Family Size: _______________

I am providing the information above for the purpose of receiving Financial Assistance from Lindquist Dental Clinic for Children. I confirm that the information above is true and represents the full household. I understand that the Financial Assistance application must be completed on an annual basis, including new proof of income, in order to continue to receive Financial Assistance. If there is a change in the information provided above I will update the application on file with the new information.

Signature: ____ Date: ____________________

Financial Agreement

This form is a financial agreement between myself and Lindquist Dental Clinic for Children (LDCC).

_____ You did not apply for Financial Assistance

_____ You do not qualify for Financial Assistance

_____ You qualify for Financial Assistance

Based on your family size and gross household income you provided, you qualify for Financial Assistance. LDCC is able to provide dental services for your child/children:

_____ at ______% off of our fees for services provided (also known as a Sliding Fee Scale)

_____ at ______% off of your patient portion not paid for by your insurance

_____ No out of pocket costs for **covered** services due to your TriCare Dental Insurance coverage and military status

You have the following payment options:

A ***minimum payment of 25% of the open balance or the family balance is due at time of service, OR*** you have a ***current and up to date payment plan.***

Recurring monthly payments using your credit card or debit card on file. Payments will be either the total divided by 12 months, or your balance divided evenly per month for equal monthly payments (no less than $40 per month), whichever is greater, until the balance is paid:

_____ Balance of $ ______________split evenly over 12 months

_____ An amount of $_________ monthly for _________ months.

_____ Payment made in full at time of each service

By signing this form I am entering into a financial agreement with LDCC and agree to pay my portion of dental services provided as noted above. Future appointments will not be made until account is brought current.

____
Print Name

____________________________________ _________________
Signature Date

Email you would like receipt for payments to be sent to: ____

If no email is provided receipts will be mailed to the address on file.

Internal LDCC Use		
Income verified by: ________________	Financial assistance added: ________________	Recurring billing est: _______________