Pender County Dental Clinic

910-259-1503
910-259-1511 Fax

Dear Patients

The Pender Dental Clinic provides services based on a sliding fee scale determined by your income and family size.

You need to bring one proof of income such as:

- Copy of last year's taxes
- Disability
- Social security retirement
- Signed statement from employer on a letter head paper and phone number (when payment is cash)

Estimado paciente:

La clinica dental provee servicios y el costo es basado en sus ingresos y el tamaño de su familia. Para determinar su costo por visita usted necesita proveernos con una de las siguientes pruebas.

- Una copia de la forma des sus impuestos de el año pasado
- Cuanto resibe por desabilidad
- Cuanto resibe por retiro de el Seguro Social
- (cuando el pago es en efectivo) Una carta firmada en papel official y con el membrete de su empleador que tambien incluya el numero de telefono para verificasion.

FINANCIAL ELIGIBILITY APPLICATION

Purchase of Medical Care Services
DHHS – Controller's Office
1904 Mail Service Center – Raleigh, NC 27699-1904

FOR POMCS USE ONLY

1. Last Name First Name MI

2. Patient SS # ___ — ___ — ____

3. Date of Birth Month Day Year

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language _____ Select from the list on the back of this form

7. County of Residence

8. Address Street or RFD

9. City State Zip Code

10. Telephone Number: Home Work

11. Program

12. Case Number

13. NC Resident ☐ Yes ☐ No If **yes**, select one of the following:
(Applicants to ADAP need only answer Y/N)
☐ 1. US citizen who lives in NC and intends to make NC his permanent home
☐ 2. Non citizen who has applied for US citizenship. INS documentation required
☐ 3. Non citizen who has a permanent resident visa or has applied for one (INS documentation required)
☐ 4. Migrant farmworker according to the federal definition
Migrant (Farmworker) Health Program Eligibility Application (DHHS 3753) require
Note: Migrant farmworker status meets the residency requirement for all POMCS progra

14. Countable Family Members
Number of Adults _____
Number of Children _____
Total Number _____

15. Earliest Requested Date of Program Coverage
Month Day Year

INCOME FORMULAS: Regular (R) – Continuously employed wage earners list income for the 12 months before the date of application or the requested date of coverage, whichever is earl
Unemployment (U) – Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date
application or the requested date of coverage, whichever is earlier. Cancer Program and ADAP are based on gross income. Must report Gross and Net Income for ADAP.

16. Complete for All Countable Family Members

Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for 12 Month Period	Dates From	Dates To	Gross Income	Income After T (Not for ADAP Cancer Progra

17. Explanations: Dates unemployed; means of support if income is low; etc.

18. **Annual Gross Income** (Stop here for Cancer Program *only*. For ADAP include Annual Gross Income and Annual Net Income.) $

Federal, State & Soc. Sec. Tax

Income After Taxes

Total Income After Taxes (Sum of Both Lines) $

Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage $

Other deductions: (Specify) $

Total Deductions $

Annual Net Income (All Other Programs) $

19. Eligibility for Other Programs Medicaid ID # _____
Medicare: ☐ Part A ☐ Part B ☐ Part D Medicare # _____
Social Security LIS Application ☐ Yes ☐ No
VA Benefits: Are you a veteran? ☐ Yes ☐ No
Did you actively serve in any branch of the military for over 180 days? ☐ Yes ☐ No
Did you receive an honorable or general discharge? ☐ Yes ☐ No

20. Was patient's problem caused by an accident? ☐ Yes ☐ No
If yes, liability compensation is ☐ Pending ☐ Awarded ☐ Ruled Out
Give attorney's name, address and phone number in block #17.

21. HEALTH INSURANCE COVERAGE Provide complete insurance information and copies of insurance cards for **all** countable family members.

Company _____
Policy No. _____
Claims Address _____
Telephone _____
Policyholder _____
Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

Company _____
Policy No. _____
Claims Address _____
Telephone _____
Policyholder _____
Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

22. I hereby certify that I have read or the interviewer has read to me the terms and conditions contained on the back of this form and that I agree to comply with them. I also certify that I have been provided opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicant's Signature _____ Relationship to patient _____ Date _____

23. I certify that I have explained the terms and conditions contained on the back of this form to the applicant and have witnessed his signature.

Type or Print Interviewer's Name _____ Agency Name _____ Date _____

Interviewer's Signature _____ Street Address/P.O. Box _____ Phone _____

City/State/Zip Code _____

See instructions on back