West Kootenay Community TEETH Clinic Society
Dental Office Client information FORM

CONTACT Information:

Address _____City _____Postal code _____

Phone_____ _____ _____
Home Cell Work
Email: _____

Can do short notice appointment ____ How much notice is needed _____

Client information

Please provide names, birthdates & **P**ersonal **H**ealth **N**umber's (**PHN**) of all 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, and **D** if they need a denture.

__Client _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No.
Birthdate

__Spouse_____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

Children:

__Oldest _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No.

__Next _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

__Next _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

__Next _____ _____ _____ male _ __/___/___ _____
(First) Initial) (Last) Female_ dd/mm/yy Personal Health No

Verifier's name:_____ _____ ____/_____/_____
Print **signature** **dd/ mm /yy**

Please scan and email to teethclinicwk@gmail.com or fax to 250 352-2282
If this is a denture case, please let clients know they will go on a wait list

West Kootenay Community TEETH Clinic Society
FINANCIAL / RESIDENCY APPLICATION

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

This information has been freely provided and the notice understood as indicated by my signature.

Name _____ _____ _____ DOB _____
(First) (Initials) (Last) dd/mm/yy
Number of Dependants? _____ Phone No._____

Address _____City_____Postal code _____

Personal Health No.:_____ Email _____

Do you identify as aboriginal? yes_____ no_____

Residency:
Proof of 3 months in Kootenay Boundary: Yes __

Financial:
Do you receive any form of income support? yes___ no___

Is your family income less than $30,000? yes___ no___

(**For Verifier Only**)
Confirmed: yes___ no____

Verified: yes___ no___

Verified: yes___ no___

I declare the above information is correct and accurately reflects my financial situation. I am aware this is not a free service and I am responsible for dental services costs.

Date___/____/_____ Signature of applicant_____
dd/ mm /yy

(for verifier only): List the types of proof submitted:_____

_____, _____ _____
print verifier's name **verifier's signature** **Date**

See brochure for verification locations
Email: verified forms to teethclinicwk@gmail.com **or fax to 250 352-2282**

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)
Email verified forms to teethclinicwk@gmail.com **or fax to 250 352-2282**If Adjusted Net

Income from line (10) above exceeds $30,000. but there are extra-ordinary expenses please complete page 4.

Financial Disclosure Worksheet for Applicants with more than $30,000, net family income but with significant extra-ordinary expenses.

Applicants require extra expenses to bring the income below $30,000 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 $30,000.00 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

Email all verified forms to teethclinicwk@gmail.com **or fax to 250 352-2282**

Jan. 31/18