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 regards 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) mm/dd/yy
Number of Dependents? _____ Phone No._____

Address _____City_____ Postal Code _____

Personal Health No _____ Email _____

Do you identify as aboriginal? yes_____ no____ If yes, ID # _____

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___

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_____
mm/dd/yy

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

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

Email: all verified forms to teethclinicwk@gmail.com
Or mail to TEETH Clinic, 632 Front St. Nelson, BC. V1L 4B7 (250.352.3543)
Individuals need only complete page 1. **BUT** families need to complete page 1 & 2.

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, **D** if they need a denture and **M** if on medication. Please bring a list of the medications to your appointment.

Please Print clearly in Black Ink.

	(First and Last Name)	M/F	Birthdate (mm/dd/yy)	Personal Health #
_____	Client _____	__	__/__/__	_____
_____	Spouse _____	__	__/__/__	_____
Dependents/Children				
_____	Oldest _____	__	__/__/__	_____
_____	Next_____	__	__/__/__	_____
_____	Next_____	__	__/__/__	_____
_____	Next_____	__	__/__/__	_____

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)

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.