



# West Kootenay Community TEETH Clinic 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. **Only print and complete page one if single. Please print your information clearly in black ink.**

Name \_\_\_\_\_ M/F \_\_\_ DOB \_\_\_\_\_  
(First) (Initials) (Last) mm/dd/yy

**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 \$42,000? yes \_\_\_ no \_\_\_

Do you identify as aboriginal? yes \_\_\_ no \_\_\_ If yes, ID # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Personal Health No \_\_\_\_\_ Email Address: \_\_\_\_\_

Please put the letter **E** in space behind the last name above, if dental pain or infection, **D** if a denture is needed and **M** if on medication. Clients need to bring a list of their medications to their appointment.

Can you do short notice appointment? \_\_\_ How much notice is needed? \_\_\_\_\_

Phone \_\_\_\_\_  
Home Cell Work

I declare the above information is correct and accurately reflects my financial and residency situation. **I am aware this is not a free service and I am responsible for dental services costs.** This information has been freely provided and the notice understood as indicated by my signature.

Date \_\_\_/\_\_\_/\_\_\_ Signature of applicant \_\_\_\_\_

**Section TO BE COMPLETED BY VERIFIERS ONLY** – List the types of proof submitted:

\_\_\_\_\_  
**Print Verifier's Name**

\_\_\_\_\_  
**Verifier's Signature**

\_\_\_\_\_  
**Date**

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Please see pamphlet for verification locations.

Email: all verified forms to [teethclinicwk@gmail.com](mailto:teethclinicwk@gmail.com) Or mail to TEETH Clinic, 632 Front St. Nelson, BC. V1L 4B7 (250.352.3543) To register additional family members, please, complete page 2 as well.



**West Kootenay Community TEETH Clinic – Only to be completed and submitted if there are additional family members.**

Please provide names, birthdates & **Personal Health Number's (PHN)** of additional 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 #
_____ Spouse _____	_	_ / _ / _	_____
Dependents/Children			
_____ Oldest _____	_	_ / _ / _	_____
_____ Next _____	_	_ / _ / _	_____
_____ Next _____	_	_ / _ / _	_____
_____ Next _____	_	_ / _ / _	_____

**Only To be completed for Individuals requiring The Adjusted Income Process.**

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)

<b>SECTION A: Net Family Income</b>	
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)
<b>Total Net Income (add lines 1 &amp; 2)</b>	<b>\$ _____ (3)</b>

<b>SECTION B:</b>	
Enter your monthly income x 12	\$ _____ (A)
Enter your spouse's or common-law partner's monthly income X 12	\$ _____ (B)
<b>Total Net Income (add lines A, B)</b>	<b>\$ _____ (AB)</b>

<b>SECTION C:</b> Answer following questions appropriately.	<b>SECTION E</b> (for office use: lines 4 through 6 have a "yes" value of \$3,000.)
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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)
<b>Total deductions (add lines 4 to 8)</b>		\$ _____ (9)
<b>SECTION D:</b>		
<b>Adjusted Net Income (subtract line 9 from line 3 or line A,B,C)</b>		<b>\$ _____ (10)</b>

I declare the information that I have provided for my income and deductions is correct and accurately reflects my financial situation.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

(note income needs to be verified on page one of form)

If Adjusted Net Income from line (10) above exceeds \$42,000. but there are extra-ordinary expenses please complete page 4.

**Financial Disclosure Worksheet** for Applicants with more than \$42,000, net family income but with significant extra-ordinary expenses.

Applicants require extra expenses to bring the income below \$42,000 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)	
	\$ _____
	\$ _____
	\$ _____
	\$ _____
	\$ _____
	\$ _____
	\$ _____
<b>TOTAL Expenses</b>	\$ _____
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 \$42,000.00 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.**