Serving Saipan since 1972

Saipan Seventh-day Adventist
Application for Dental Assistance

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HOW DO I QUALIFY? All applicants are asked to provide proof of household income and family size to qualify for discounted fees. There is a 30-day grace period from the date of your visit to the time the complete application needs to be returned. If the application is not returned within 30 days, you will be responsible for 100% charges. If the application is returned within 30 days and the patient qualifies on the scale, adjustments will be made starting with the date the application was first provided to the patient.

DEFINITION OF FAMILY SIZE: All members of a household who are related and pooling financial resources are counted as one family if the arrangements are considered permanent and support greater than room and board is provided. Unrelated members of a household who are supporting one another financially are considered one family.

DEFINITION OF INCOME: Income is defined as total money before taxes from all sources, which can include: earning, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, Savings accounts (average balance of past 6 months' activity, divided by 6 months' equal monthly portion of income), and other miscellaneous sources.

Non-cash benefits (such as food stamps and housing subsidies) do not count.

NOMINAL FEE: Saipan Seventh-day Adventist Clinic requires that patients otherwise eligible for 100% discount pay a nominal fee of $10.00 each visit.

EXCLUDED CHARGES: The following charges are excluded from eligibility for discount:

- General Anesthesia fee
- Outside Lab fees
- Outside Prescription costs
- Orthodontics (braces)
- Crowns
- Other procedures deemed as cosmetic or unnecessary

WHEN DO I NEED TO REAPPLY: After one-year, or anytime your income, household size and/or medical insurance status changes.

WHAT MUST I PROVIDE? In addition to this complete application, you must provide:

- Copy of two most recent check stubs
- Last Year's IRS Form 1040
- Verification of other income (1099s, SSI Statement, etc.)
- Copy of Valid ID (Passport, Driver's license, Mayor's ID, etc.)
- If you do not qualify for Medicaid, a copy of your denial letter
- Proof of Residency (such as CUC bill, house rental receipt, notarized affidavit of living arrangements)
- Other documents as requested

APPLICANT INFORMATION

First Name:	Middle:	Last:	
Date of Birth:	Social Security:	Tel:	Email:
Mailing Address:	City:	State:	Zip:

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other ☐ Please Specify: _____

HOUSEHOLD MEMBERS

Full Name	Date of Birth	Social Security	Relationship	Current Employer

INCOME

Monthly Income	Self	Spouse	Children	Others	Subtotal
				Total ▷	

I authorize Saipan Seventh-day Adventist Clinic to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and /or subject to legal action for knowingly providing false information. I agree to notify Saipan Seventh-day Adventist Clinic of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above.

_____ _____

Signature of Applicant Date

FOR OFFICIAL USE ONLY

Verified Annual Income: $ _____ Family Size: _____

Approved ☐ Denied ☐

Approved Treatment Plan: _____

Reviewed by Financial Officer: _____

Approved for Sliding Fee: Nominal ☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐