CAROLINA FELLOWS FAMILY DENTISTRY
GRANVILLE-VANCE PUBLIC HEALTH
FINANCIAL ELIGIBILITY WORKSHEET

Patient Name: _____

DOB:_____/_____/_____

TYPES OF INCOME

☐Salaries, wages, overtime pay, commissions, fees, tips
☐Earnings from self-employment
☐Interest earned on investments
☐Public assistance money
☐Unemployment compensation
☐Military allotments
☐Allowances paid for basic living expenses
☐Educational stipends in excess of the cost of tuition and books
☐ Regular contributions from individuals not living in the household
☐All other sources of cash income except those specifically excluded
☐Supplemental Security Income (SSI) benefits
☐Other (specify) _____

☐Worker's compensation
☐Alimony and child support
☐Social Security benefits
☐Retirement and pension payments
☐Income tax refunds
☐Veteran's Administration benefits
☐Prize winnings
☐Bank statements
☐Disability
☐Cash earnings, contributions received
☐Dividends

An economic unit includes persons living in the household, related or non-related, who share their production of income and consumption of goods. Please determine the number of persons contributing to the gross annual income of the household on an annual basis. Please indicate if they receive this income on a weekly, bi-weekly, bi-monthly, or monthly schedule, along with their total income for the overall year.

Example:

NAME(s)	**EMPLOYER**	**GROSS INCOME:** WEEKLY *(multiply by 52)* BI-WEEKLY *(multiply by 26)* BI-MONTHLY *(multiply by 24)* MONTHLY *(multiply by 12)*	**GROSS INCOME: ANNUAL**
Jane Doe	Walmart (pay stub)	$200 x 52 = $10,400	$10,400
John Doe	Self-employed (tax forms)	$18,200	$18,200

TOTAL INCOME $28,600

NAME(s)	**EMPLOYER**	**GROSS INCOME:** WEEKLY *(multiply by 52)* BI-WEEKLY *(multiply by 26)* BI-MONTHLY *(multiply by 24)* MONTHLY *(multiply by 12)*	**GROSS INCOME: ANNUAL**

TOTAL INCOME: _____

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DOB: _____/_____/_____

Total number in household supported by income on page 1: _____

Number of children in household (include any current pregnancies): _____

Name (Child 1): _____

Name (Child 2): _____

Name (Child 3): _____

Name (Child 4): _____

I agree to pay _____% of all charges.

☐ I prefer not to provide proof of income; therefore, I understand that I am fully obligated for payment of fees for services provided at 100% of _____'s current fees.

☐ Proof of income has been provided. I understand that I am fully obligated for payment of fees for services provided at ____% of the current fees.

☐ Proof of income will be provided within 3 calendar days of signature date below. I understand if proof of income is not provided within the 3 calendar day period, charges will remain at 100% of current fees.

I verify the above information is true to the best of my knowledge and I understand payment is expected at the time of service for all services rendered.

_____ _____
Signature of Patient/Parent/Legal Guardian Relationship

_____ _____/_____/_____
Signature of Witness Date