RICE REGIONAL DENTAL CLINIC

301 Becker Ave SW, Willmar, MN 56201
Appointments (320) 214-2620
Toll Free (877) 214-2611
Fax (320) 214-2630

Rice Memorial Hospital

SLIDING FEE APPLICATION

You must attach a copy of your most recent *Federal Form 1040*

This application will not be accepted until total household income information is attached.

APPLICANT INFORMATION			
Name:			
Current address:			
City:	State:	Zip:	County:
Date of birth:	SSN:		Household Size:
Home Phone:	Cell Phone:		

SPOUSE/OTHER ADULT INCOME INFORMATION		
Name:	Cell Phone:	
Date of birth:	SSN:	Work Phone:

DEPENDENT CHILDREN			
Name	Date of Birth:	Name	Date of Birth:
Name	Date of Birth:	Name	Date of Birth:
Name	Date of Birth:	Name	Date of Birth:

APPLICANT EMPLOYMENT & INCOME INFORMATION		
Employer Name & Address:		
Position:	Hourly Salary *(Please circle)*	Annual income:
Other Income:	Monthly:	Annual income:

SPOUSE/OTHER ADULT EMPLOYMENT & INCOME INFORMATION		
Employer Name & Address:		
Position:	Hourly Salary *(Please circle)*	Annual income:
Other Income:	Monthly:	Annual:

SIGNATURES

I understand that this application must be accompanied by written verification of annual household income. Misrepresentation will result in immediate termination of sliding fee benefit. Rice Regional Dental Clinic reserves the right to recapture sliding fee discounts the household has received under false representation.

Signature of applicant:	Date:
Signature of spouse:	Date:

FOR CLINIC USE ONLY

Total Annual Household Income: $		Eligible for Sliding Fee: Yes No	
STAFF SIGNATURE:	**DATE:**	**LAST DENTIST NAME:**	**DATE OF LAST VISIT:**