Keystone Dental Care, Inc.

Date:

Assistance Plan Application

It is the policy of Keystone Dental Care Inc. to provide essential dental services. Fees are determined depending upon family income and size. Please complete the following information to determine if you or members of your family ages 19 years and above are eligible for treatment. In the hope that your economic health improves, discounts apply only for a one year period.

Patients Name	Place of Employment

Please list household members **Number of people in Household** ___________

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

ANNUAL HOUSEHOLD INCOME

Please list income from any of these sources	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotment				
Income from self employment, and dependents				
Other Income				
Total Income				

Verification Checklist (attach copies)	Yes	No
Income: Prior year tax return, three most recent pay stubs, verification of alimony, verification of child support, copy of social security income, or other		

I certify that the information shown above is correct and understand verification is required before treatment is approved.

Signature ______________________________ Date ____________

Office Use Only

Pay class approved: ____________________ Effective date: ____________________

Approved by: ____________________ Expiration date: ____________________