Pender County
Health Department

...Building a healthier tomorrow…

Carolyn Moser, BSN, MPA
Health and Human Services Director

Dear Patients,

The Pender County Dental Clinic provides services based on sliding fee scale determined by your income and family size.

You need to bring one proof of income such as:

- Copy of last year's taxes
- Disability income
- Social Security Retirement
- A signed statement from employer on letter head paper with phone number (when paid in cash)
- A month's worth of recent paystubs

Estimados pacientes,

La Clínica Dental del Condado de Pender brinda servicios basados en una escala móvil de tarifas determinada por sus ingresos y el tamaño de su familia.

Debe traer un comprobante de ingresos como:

- Una copia de los impuestos del año pasado
- Cuanto resibe por desabilidad
- Cuanto resibe retiro del Seguro Social
- (cuando el pago es en efectivo) Una carta firmada en papel official y con membrete de su empleador que tambien incluyda el número de teléfono para verificasion
- Un mes de recibos de pago de salario

Pender County Health Department **803 S. Walker St., Burgaw, NC 28425**

Dental Clinic (910) 259-1503 **Environmental Health (910) 259-1233** **WIC (910) 259-1290**

FINANCIAL ELIGIBILITY APPLICATION

Purchase of Medical Care Services
DHHS – Controller's Office
1904 Mail Service Center • Raleigh, NC 27699-1904

FOR POMCS USE ONLY

1. Last Name First Name MI

2. Patient SS # ___ ___ ___ – ___ ___ – ___ ___ ___ ___

3. Date of Birth: Month | Day | Year

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language ______ Select from the list on the back of this form

7. County of Residence

8. Address Street or RFD

9. City State Zip Code

10. Telephone Number: Home Work

11. Program

12. Case Number

13. NC Resident ☐ Yes ☐ No If **yes**, select one of the following:
(Applicants to ADAP need only answer Y/N)
☐ 1. US citizen who lives in NC and intends to make NC his permanent home
☐ 2. Non citizen who has applied for US citizenship. INS documentation required
☐ 3. Non citizen who has a permanent resident visa or has applied for one (INS documentation required)
☐ 4. Migrant farmworker according to the federal definition
Migrant (Farmworker) Health Program Eligibility Application (DHHS 3753) required
Note: Migrant farmworker status meets the residency requirement for all POMCS programs

14. **Countable** Family Members
Number of Adults ________
Number of Children ________
Total Number ________

15. Earliest Requested Date of Program Coverage: Month | Day | Year

INCOME FORMULAS: Regular (**R**) – Continuously employed wage earners list income for the 12 months before the date of application **or** the requested date of coverage, whichever is earlier. Unemployment (**U**) – Wage earners unemployed at the time of application or for 30 consecutive days during the previous 12 months list income for 6 months before and after the date of application **or** the requested date of coverage, whichever is earlier. Cancer Program and ADAP are based on gross income. Must report Gross and Net Income for ADAP.

16. Complete for **All** Countable Family Members

Name	Relationship to Patient	Income Formula (R or U)	List all Employers or Sources of Income/Reason for None for **12 Month Period**	Dates From	Dates To	Gross Income	Income After Tax *(Not for ADAP or Cancer Program)*

17. Explanations: Dates unemployed; means of support if income is low; etc.

18. **Annual Gross Income** (Stop here for Cancer Program ***only***. For ADAP include Annual Gross Income and Annual Net Income.) $
Federal, State & Soc. Sec. Tax
Income After Taxes
Total Income After Taxes (Sum of Both Lines) $____________
Medical expenses paid or incurred during past 12 months not covered by a third party nor requested for program coverage $____________
Other deductions: (Specify)________________________ $____________
Total Deductions $____________
Annual Net Income (All Other Programs) $____________

19. Eligibility for Other Programs Medicaid ID # __________________
Medicare: ☐ Part A ☐ Part B ☐ Part D Medicare # __________________
Social Security LIS Application ☐ Yes ☐ No
VA Benefits: Are you a veteran? ☐ Yes ☐ No
Did you actively serve in any branch of the military for over 180 days? ☐ Yes ☐ No
Did you receive an honorable or general discharge? ☐ Yes ☐ No

20. Was patient's problem caused by an accident? ☐ Yes ☐ No
If yes, liability compensation is ☐ Pending ☐ Awarded ☐ Ruled Out
Give attorney's name, address and phone number in block #17.

21. HEALTH INSURANCE COVERAGE Provide complete insurance information and copies of insurance cards for **all** countable family members.

Company____________________
Policy No.____________________
Claims Address____________________
____________________Telephone____________________
Policyholder____________________
Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

Company____________________
Policy No.____________________
Claims Address____________________
____________________Telephone____________________
Policyholder____________________
Is patient covered? ☐ Yes ☐ No Is this an **HMO**? ☐ Yes ☐ No

22. I hereby certify that I have read or the interviewer has read to me the terms and conditions contained on the back of this form and that I agree to comply with them. I also certify that I have been provided opportunity to ask the interviewer questions about these terms and conditions and that I understand the answers I was given.

Applicant's Signature ____________ Relationship to patient ____________ Date ____________

23. I certify that I have explained the terms and conditions contained on the back of this form to the applicant and have witnessed his signature.

Type or Print Interviewer's Name ____________ Agency Name ____________ Date ____________

Interviewer's Signature ____________ Street Address/P.O. Box ____________ Phone ____________

City/State/Zip Code ____________