



WE WILL NEED COPIES OF THE FOLLOWING ITEMS ALONG WITH YOUR COMPLETED APPLICATION:

- Two current pay stubs (for proof of income and hours worked) for anyone working in your household.
- If over the age of 65, provide social security/pension/retirement proof of income
- One utility bill with your current name and address (for proof of address)
- Valid Tennessee Driver's License
- Social Security Card
- If self-employed, provide current tax return
- If a student, provide proof of student enrollment

RETURN COMPLETED ORIGINAL APPLICATION, ALONG WITH DOCUMENTATION TO THE INTERFAITH DENTAL CLINIC. WE DO NOT ACCEPT APPLICATIONS BY FAX or E-Mail.

You may mail or bring your application and documents to:

Interfaith Dental Clinic

1721 Patterson Street

Nashville, TN 37203

Applications are accepted Monday through Thursday between the hours of 8 am to 11 am and 2 pm to 4:30 pm.

NOTE: APPLICANT MUST CALL ONE – TWO WEEKS FROM DATE OF SUBMISSION OF APPLICATION TO VERIFY STATUS OF ACCEPTANCE INTO THE PROGRAM.



Program Application

Office Use Only Date App. Rcv'd: _____ Approved/Pending/Denied Fee Schedule: A B C D _____ Reason Pending: _____ _____ _____ 1st NP Appt Date: _____
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Please answer all questions or your application will not be reviewed!

Instruction: The head of household is to complete this entire form. List all forms of income (including spouses'/live in boyfriend/girlfriend income) and attach copies of the proof. Without proof of income, your application will be considered incomplete and will not be reviewed until proof is brought in. We may require an update of information every 6 months.

Head of Household Information

Name _____ Social Security # _____ - _____ - _____

Address _____ Date of Birth: _____ Age: _____

City, State, Zip _____

County _____ Home Phone _____ Cell Phone _____

Employer _____ County Employer is located in: _____

If self employed what type of work: _____

Work Phone _____ # of Hours Worked per Week _____

Head of Household Wages per hour or Gross Salary per Year _____

Marital Status : (Circle One) Single Married Widowed Divorced Separated

Complete the following section regarding your spouse, live in girlfriend/boyfriend, fiancée.

Spouse Name: _____ Spouse Social Security # _____ - _____ - _____

Date of Birth: _____ Age: _____ Spouse Employer _____

Spouse Work Phone _____ County Spouses Employer is located: _____

Spouse Hours Worked per Week: _____ Spouse Wages per Hour or Year _____

Do you pay child support? (Circle One) Yes No If yes, how much do you pay per month? _____

Do you or your spouse receive any other type of income? **Alimony, Social Security, Inheritance, child support, retirement, pension, etc.** If yes, how much per month? _____

People Living in Household: _____ # of children: _____ Ages of children: _____

Please list all the people who live in your household. Include yourself and put children last. Place an (X) by the ones who are interested in becoming IFDC patients.

X	Name	Relation to Head of Household	Date of Birth	Hrs wrkd per week/rate of pay
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Family Information:

Other than public school, are you or anyone in the family in school? (Circle One) Yes No

If yes, please state number of hours, yearly tuition, and name of the persons in school: _____

Do you or anyone in the family have TennCare? (Circle One) Yes No

Do you or anyone in the household have dental insurance? (Circle One) Yes No

Do you or anyone in the household have medical insurance? (Circle One) Yes No

If you answered yes to any of the questions above, please provide the information below.

Name of the insured	Insurance Co	ID Number	D-Dental M-Medical

Living Expenses:

Item Monthly	Amount	Item Monthly	Amount
Rent or Mortgage		Total amount for utilities	
Phone		Credit card payments	
Child Care		Cable	
Groceries		Car/Insurance	
Medical		Other	

_____ I still live at home with my parents but I am financially responsible for myself. The amounts listed above is what I contribute to the household.

Cash on Hand:

Checking \$ _____ Savings \$ _____ 401k or IRA \$ _____ Other \$ _____

Head of Household:

Who is your primary dentist? _____

Date and purpose of your last dental visit: _____

Current dental problem and needs: _____

Have you been a patient here before? _____ If so, when? _____

What is your religious affiliation? (Optional) _____

What Church do you attend? (Optional) _____

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If we have further questions regarding your application who should we contact?

Name: _____ Phone# _____

In case of an emergency who should we contact? Please advise of someone that does not live in your household.

Name: _____ Relationship: _____

Home# _____ Cell# _____ Work# _____

How did you hear about our program? _____

If referred please list name and address of that person _____

Are you currently a "Bridges To Care" participant? _____

If accepted into the Interfaith Dental Clinic I/We agree to the following :

I will keep my teeth clean and will encourage my family to keep their teeth clean.
I/We will keep appointments or will give 48 hours notice of cancellation, or there will be a \$25 cancellation fee.

I agree to pay all debts incurred at Interfaith Dental Clinic.

Failure to comply with the above statements will result in denial of further treatment.

Signature _____ **Date** _____

For Office Use Only:

Is application complete? Yes No Pending

Date application completed _____ **Accepted** **Denied**

Notes: _____
