

**WE WILL NEED COPIES OF THE FOLLOWING ITEMS
SUBMITTED 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.
- Proof of address (utility bill, bank statement, etc.).
- If self-employed, provide current tax return.
- If a college student, provide current class schedule.

**RETURN COMPLETED APPLICATION, ALONG WITH
DOCUMENTATION TO THE INTERFAITH DENTAL CLINIC.
WE DO NOT ACCEPT APPLICATIONS BY FAX.**

You may e-mail or bring your application and documents to:

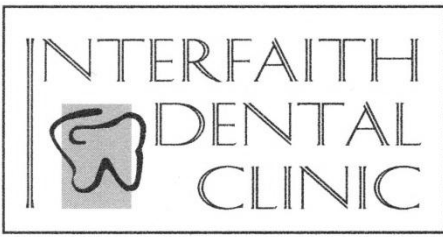
Interfaith Dental Clinic of Rutherford County
210 Robert Rose Dr. Second Floor
Murfreesboro, TN 37129

Michelle@interfaithdentalclinic.com

Applications are accepted during clinic hours.

You will be contacted upon review of your application.

Please answer all questions or your application will not be reviewed!



CLINIC GUIDELINES/RULES

To provide you with the quality care that you deserve, we ask that you do your part by agreeing to the following clinic guidelines.

Program information:

- **Interfaith Dental Clinic is a one-time opportunity!** (the average patient is in our program for approximately 1 year)
- Upon completion of treatment you will be scheduled for an exit exam and final cleaning. If no additional treatment is needed you will graduate our program.
- When you graduate or are dismissed from our program further care is your own responsibility and must be received elsewhere.
- If you discontinue treatment for longer than six months, you will be automatically dismissed.

Financial/Employment Status:

- You must keep us aware of current income and employment information.
- You must advise the staff of any dental insurance.
- You may be required at any time to provide proof of employment and income.

Patient Care:

- Various volunteer dentists, specialists, dental assistants, hygienists, students/surgeons in training and Interfaith staff will be providing your care.

Appointment Policy:

- All scheduled appointments must be kept or you must give a **48 hour** notice to cancel or reschedule. Failure to do so will result in a \$25.00 charge.
- The second time an appointment is cancelled without a 48 hour notice or missed you will be dismissed from the program.
- You are giving us permission to leave a message regarding your appointments. Confirmation calls of appointments are a courtesy. When we leave a message we would appreciate a call back to confirm your appointment.

We reserve the right to cancel any appointments based upon the following conditions:

- A past due balance.
- A returned check.
- Failure to maintain adequate oral hygiene.
- Missed appointments.
- Failure to provide current contact information.

Payment Policy:

- You must pay your bill in full at each appointment.
- You must pre-pay for any appointment that requires sedation.
- We reserve the right to request prepayment for various procedures.
- If your account is delinquent and is turned over to our attorney and/or collection agency, you are responsible for any fees associated with the collection of your account.
- If you have treatment plan or account questions please contact a patient care coordinator.

Returned Check Policy:

- A fee of \$20.00 in addition to the check amount will be due and payable by cash, debit, or credit only before you can proceed with further treatment. Future payments will only be accepted in the form of cash, credit or debit.

Photo:

- I give permission for my family's photos to be used for fundraising purposes. (Circle One) Yes No

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.

I have read, understand and agree to the above listed clinic guidelines for myself and my family.

Signature: _____ Date: _____

Print Name: _____

Program Application

Instructions: 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 processed and you will need to completely reapply. We may require an update of information every 6 months

Head of Household Information

Full Name _____ Preferred Name _____ Sex _____
 Marital Status: (Circle One) Single Married Widowed Divorced Separated
 Date of Birth: _____ Age: _____ SS# _____-_____-_____
 Race: (Circle One) White, Black, Hispanic, Asian, Middle East, Eastern Europe, Other _____
 County You Live in _____ County You Work In: _____
 Home Address _____
 City, State, Zip _____
 Home Phone _____ Cell Phone _____ Other _____
 Employer _____ Occupation _____
 If self-employed what type of work (Please include copy of Tax Return) _____
 Work Phone _____ # of Hours Worked per Week: _____
 Please list wages _____ per hr/ _____ per week/ _____ per month
 Are you applying for services at Interfaith? _____ Have you been a patient here before? _____
 Are you currently attending college? (Circle One) Yes No
 If yes, please state number of hours and yearly tuition. (Please include a copy of your current class schedule) _____
 Do you have TennCare or CoverKids? (Please circle which one)
 Do you have dental insurance? (Circle One) Yes No
 Do you have medical insurance? (Circle One) Yes No
 If you answer yes to any of the questions above, please provide a copy of your insurance card.
 Do you pay child support? (Circle One) Yes No If so how much do you pay per month? _____
 Do you receive any other type of income? Alimony, Social Security, Inheritance, Child Support, Retirement, Pension, Food Stamps, etc. If yes, list type and how much per month?

 What Church do you attend? (Optional) _____
 How did you hear about our program? _____
 If referred please list name of that person _____
 Are you currently a "Bridges To Care" participant? (Circle One) Yes No
 Do you have a case worker? (Circle One) Yes No
 If so, please list name and phone number. _____

Living Expenses:

Item Monthly	Amount	Item Monthly	Amount
Rent/ Mortgage(Circle One)	_____	Total Amount for Utilities	_____
Phone	_____	Credit Card Payments	_____
Child Care	_____	Cable/Internet/Dish	_____
Groceries	_____	Car Payment & Insurance	_____
Medical Insurance & Bills	_____	Other	_____

Cash On Hand:

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

Please complete an additional box for each individual who lives in your household that you are financially responsible for. (Ex: spouse, live in girlfriend/boyfriend, fiancée, child, parent, etc.)

Full Name _____ Preferred Name _____ Sex _____
Marital Status: (Circle One) Single Married Widowed Divorced Separated
Date of Birth: _____ Age: _____ SS# _____ - _____ - _____
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Home Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Other _____

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How did you hear about our program? _____

If referred please list name of that person _____

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Do you have a case worker? (Circle One) Yes No

If so, please list name and phone number. _____

If more family members please fill out information on back of this sheet.

For Office Use Only:

Date App. Rcv'd: _____

Date application processed _____

Fee Schedule: A B C D

Approved – Denied

Notes: _____

_____ hrs/wk X \$ _____ /hr X 52= _____ / year

_____ hrs/wk X \$ _____ /hr X 52= _____ / year

_____ hrs/wk X \$ _____ /hr X 52= _____ / year

12mo X \$ _____ = _____ / year

12mo X \$ _____ = _____ / year

of family members _____