Oral Health Task Force Assistance Program by Sawtooth Mountain Clinic Application

Applicant's Name ____ Date of Birth __________________________

Spouse's Name ____ Date of Birth __________________________

Address ____

Home Phone ____ Work Phone ____

Other Phone _______________________________ Email Address ____

Family children and young adults (18 months through 26 years of age):

Name ____ Date of Birth __________________________

Name ____ Date of Birth __________________________

Name ____ Date of Birth __________________________

(Attach separate sheet if more space is needed)

If you are between 19 and 26 years of age, did you grow up in Cook County? YES NO

Does the applicant have dental insurance? If so:

Dental Insurance carrier _______________________________ Policy # ___________________ Group# ______________

If you are uninsured or struggle to afford your health and dental care, you may be eligible for Sawtooth Mountain Clinic's Sliding Fee Scale program or for Medical Assistance. Please call Sawtooth Mountain Clinic to learn more about these programs and how to apply.

Are you currently enrolled in the Sawtooth Mountain Clinic's Sliding Fee Scale program? YES NO

The SMC SFS program and OHTF program are two different funding sources and each require an application to be filled out.

Oral Health Task Force Assistance Program by Sawtooth Mountain Clinic Family Size and Income Caps

Family Size _________ Family Income for the past 12 months __________________________

Family Size	Income eligibility cap
1	$69,851+
2	$94,150+
3	$118,449+
4	$142,748+
5	$167,046+
6	$191,346+
7	$215,645+
8	$239,944+

If you or your family income falls under the eligibility cap, you will pay 10% of the original charges, or a $5 minimum fee, from Grand Marais Family Dentistry.

I acknowledge that I have read the instructions. The Oral Health Task Force, Grand Marais Family Dentistry, and Sawtooth Mountain Clinic may share my income and application information to determine program eligibility. I understand that the Oral Health Task Force's assistance is a defined program with service and payment limits. The Oral Health Task Force will not be responsible for bills which I may incur outside of specified limits.

Signature ___________________________________ Spouse's Signature ___________________________________ Date __________

Oral Health Task Force
PO Box 454
Grand Marais, MN 55604
218-387-2334
oralhealth@boreal.org

Sawtooth Mountain Clinic
513 5th Ave W
Grand Marais, MN 55604
218-387-2330