Income Assessment for Reduced Fee Dental Care

- Complete the form
- Send your completed form by mail, fax, email, or bring it to one of the following clinics:
  - Sheldon M. Chumir Dental Clinic  1213 4th St. SW Calgary AB T2R 0X7
    Fax: 403.955.6899 Phone: 403.955.6888
  - Northeast Dental Clinic (Sunridge Mall)  200 2580 32 St NE Calgary AB T1Y 7M8
    Fax: 403.944.9779 Phone: 403.944.9999
  - Email: community.dental@ahs.ca (please use email for program application ONLY)

Fill out this section to find out if you are eligible for reduced fee dental services

Do you receive assistance from any of these government programs? (✓)

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assured Income for the Severely Handicapped (AISH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alberta Adult Health Benefit</td>
<td></td>
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<tr>
<td>Alberta Senior’s Benefit</td>
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<tr>
<td>Alberta Student Finance Board Assistance (Student Loans)</td>
<td></td>
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<tr>
<td>First Nations Social Services Income Support</td>
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</tbody>
</table>

Did you answer Yes to any of the questions?

☐ Yes
☐ No, Continue

If you answered Yes to any of the questions, you do not qualify for reduced fee dental services.

These programs already provide you with dental benefits. Please contact them if you have questions.

Do you have a Notice of Assessment? (A notice that is sent to you when you file a tax return)

☐ No
☐ Yes, Continue

If you answered Yes, Continue.

Can you get one? (STOP)

☐ No
☐ Yes, Continue

If you answered Yes, Continue.

Do not continue this form. Use Form 20933 Temporary Eligibility Assessment to find out if you qualify for emergency/urgent dental services.

Fill this out to find and show your family income

(Use Line 236 on your Notice of Assessment)

Your yearly taxable income

$ ____________________

Your spouse/common law partner’s taxable income

$ ____________________

Total Combined Household Income

$ ____________________

What is your family size? Number of persons

Includes: You + Your spouse/partner + Number of children under age 18

<table>
<thead>
<tr>
<th>Low Income Cut-off</th>
<th>$24,949</th>
<th>$46,362</th>
<th>$66,027</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 persons</td>
<td>$31,061</td>
<td>$52,583</td>
<td></td>
</tr>
<tr>
<td>3 persons</td>
<td>$38,185</td>
<td>$59,304</td>
<td></td>
</tr>
<tr>
<td>7 or more persons</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Is your family income below the low-income cutoff?

☐ No
☐ Yes, Continue

Send/bring a copy of your Notice of Assessment for you and your spouse with this form

Fill this out for the person who is applying for reduced fee dental care

Last Name

First Name

Personal Health Number

Date of Birth (yyyy-Mon-dd)

Gender

Phone Number

Alternate Phone Number

Address

City/Town

Postal Code

Alberta Health Services collects health information in accordance with Section 20 of the Health Information Act (HIA) for the purpose of providing health services, determining eligibility for health services, or to carry out any other purpose authorized by the HIA. If you have questions about this collection, please ask your health care provider or contact Manager, Public Health Dental Services 6th Floor, 1213 4th Street SW Calgary, AB T2R 0X7, Phone 403.955.6685. 19284 (Rev2017-08)