

Income Assessment for Reduced Fee Dental Care

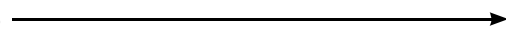


- Complete the form
- Send your completed form by mail, fax, email, or bring it to one of the following clinics:
 - Sheldon M. Chumir Dental Clinic 1213 4th St. SW Calgary AB T2R 0X7
Fax: 403.955.6899 Phone: 403.955.6888
 - Northeast Dental Clinic (Sunridge Mall) 200 2580 32 St NE Calgary AB T1Y 7M8
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? (✓)






Program Name	Yes	No
Assured Income for the Severely Handicapped (AISH)		
Alberta Adult Health Benefit		
Alberta Senior's Benefit		
Alberta Student Finance Board Assistance (<i>Student Loans</i>)		
First Nations Social Services Income Support		

Did you answer **Yes** to any of the questions?

- Yes   **You do not qualify for reduced fee dental services**
 No, Continue 

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  Can you get one?
 Yes, Continue 
- No   **Do not continue this form. Use Form 20933 Temporary Eligibility Assessment to find out if you qualify for emergency/urgent dental services**
 Yes, Continue 

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 \$ _____



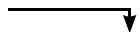
What is your family size? Number of persons _____

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

Low Income Cut-off

1 person	\$ 25,921	4 persons	\$ 48,167	7 or more	\$ 68,598
2 persons	\$ 32,270	5 persons	\$ 54,630	persons	
3 persons	\$ 39,672	6 persons	\$ 61,613		

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 (<i>yyyy-Mon-dd</i>)		Gender		Phone Number	
Address		City/Town		Postal Code	
				Alternate Phone Number	