



“In the same way, let your light shine before others, so that they may see your good works and give glory to your Father who is in heaven.”
Matthew 5:16

5:16 Clinic, Inc.

Christian Medical/Dental Mission

810 E Mt Vernon St, Somerset, KY 42501 (606)-802-2069

APPLICATION/VERIFICATION OF FINANCIAL INFORMATION

Patient's Name _____ Date _____

Social Security # _____ Phone# _____

Email _____ Date of Birth _____

Home Address _____

Employer _____ Phone# _____

Address _____

Work Fulltime or Parttime? _____ How Many Hours per Week? _____

Annual Income \$ _____ *Provide 2 months' pay stubs and most recent W2)*

Housing: (Rent/Own/Homeless) _____ Marital Status: (Single/Married/Widowed/Divorced) _____

How many people live in your home? _____ Please list each person living with you:

Name _____ SS# _____

Name _____ SS# _____

Name _____ SS# _____

Name _____ SS# _____

Do you or any members of your household receive any of the following benefits? **If so, please provide a copy of the award statements for each, and list the monthly amount received.**

Unemployment	\$	Worker's Comp	\$
Social Security	\$	Disability	\$
Child Support	\$	Kinship Care	\$
State Supplemental	\$	Medical Assistance	\$
Alimony	\$	SNAP	\$

Are other members of your household employed? _____ If so, please provide 2 months' pay stubs and their most recent W2. **What is their total annual income?** \$ _____

Your Total Household Income = All Employment Income + Benefits (listed above)

What is your Total Household Income? \$ _____

Do you have Dental Insurance? _____ Do you have Medical Insurance? _____

Do you have Medicaid? _____ If so, please provide policy # _____

How can we help you? Please describe your dental/medical needs: _____

_____ **Date** _____

Applicant Signature

By signing this application, I certify that the information contained in this form is true and correct to the best of my knowledge. I hereby grant permission for 5:16 Clinic and its agents to verify my employment, income, insurance coverage, Medicaid status and any other pertinent information needed to determine if I qualify for free dental and/or medical services.

✓ CHECK LIST: Dental/Medical HELP for Working Families

If you have questions about whether you and your family qualify, here is a check list:

- _____ Do you *live* in **Pulaski County** ?
- _____ **Someone in your household is employed** at least 32 hours per week
- _____ You **DO NOT** have **Dental Insurance**
- _____ You're **Uninsured** or **Underinsured for Medical Services**
- _____ You meet the **income guidelines** below – with **total household income*** not exceeding 200% of the Federal Poverty Rate?

*Note:**Total Household Income** includes all income from employment and all other sources received by applicant, spouse, domestic partner and all other persons living in your house.

Qualifying Income by Family Size	Maximum Annual Income
One person	\$29,160
Two people	\$39,440
Three people	\$49,720
Four people	\$60,000
Five people	\$70,280
Six people	\$80,560
Seven people	\$90,840
Eight people	\$101,120
Nine people or more	\$111,400

Please complete and submit online or mail your **completed application** to: 810 E. Mt. Vernon St, Somerset, KY 4250, along with:

- 1.** Proof of income (2 months most recent pay stubs, most recent W2, and award statements for any additional income.)
- 2.** Proof of residency (letter from landlord, utility bill, property tax bill, etc.)
- 3.** Valid photo ID (copy)

Note* We are unable to provide acute or emergency care. Patients are seen by appointment only, after approval.

***Patient Non-Discrimination Policy:** The 5:16 Clinic is committed to providing quality service to patients of all backgrounds. In accordance with this mission, the 5:16 Clinic does not exclude, deny service to, or otherwise discriminate against any person on the basis of age, sex, marital status, creed, race, color, national origin, or any other legally protected class or on the basis of disability or age in admission to, participation in or receipt of any of its services. *This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, The Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Regulations Part 80, 84, and 91,