

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 *(Student Loans)* |  |  |
| First Nations Social Services Income Support |  |  |

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

* Yes
* No, Continue

**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

Can you get one?

* + No
	+ 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*

Is your family income below the

|  |  |
| --- | --- |
| **Low Income Cut-off** |  |
| 1 person | $ 27,514 | 4 persons | $ 51,128 | 7 or more | $ 72,814 |  |
| 2 persons | $ 34,254 | 5 persons | $ 57,989 | persons |  |  |
| 3 persons | $ 42,111 | 6 persons | $ 65,401 |  |  |  |

◄ low-income cutoff?

* + - No
		- Yes, Continue

|  |
| --- |
| **Fill this out for the person who is applying for reduced fee dental care** |
| Last Name | First Name | Personal Health Number |
| Date of Birth *(dd-Mon-yyyy)* | Gender | Phone Number | Alternate Phone Number |
| Address | City/Town | Postal Code |

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

*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 (Rev2022-08)