DENTAL CLINIC
FREE REDUCTION PROGRAM

City of Fairfax residents may request a reduction of Northern Virginia Dental Clinic costs. Requests must be made in writing using the "Request for Free Reduction" application form and include supporting documentation. Request will be evaluated based on overall household income and size must fall below 200% of the Federal Poverty Guidelines.

Household Size	Income
1	$24,980
2	$33,820
4	$51,500

The Dental Clinic flat rate for each appointment is $50.00. Additional fees are charged for biopsies and the fabrication of the prosthetic appliances. All fees must be prepaid. Payments may be made in the form of cash, money order or check made out to the City of Fairfax.

APPLYING FOR A FEE REDUCTION:

1. Applications must be turned in a minimum of three weeks before the first appointment.
2. Household income is defined as the sum, on an annual basis of all pay, Social Security benefits, child support, social services allowances and other income for the household.
3. Department staff will review the application and, if completed fully with supporting documentations for verifying your income such as your W2 form, will determine the appropriate reduction in payment, if any, due for treatment.
4. All questions should be directed to the City of Fairfax Human Services, Monday through Friday, 8:30 a.m. – 5:00 p.m. at 703-385-7894 (TTY 711) or Lesley.Abashian@fairfaxva.gov.

City of Fairfax
Human Services
10455 Armstrong St., Suite 316
Fairfax, VA 22030
(703) 385-7894

Please note: Three appointment slots are typically allocated to the City each month. Depending upon the size of the waiting list, it may be two to three months before you receive the next appointment.

Northern Virginia Dental Clinic
8221 Willow Oaks Corporate Drive, 4th Floor
Fairfax, VA 22031
Telephone: (703) 820-7170 Fax: (703) 820-7229

REFERRAL/INVOICE FORM

DATE:			
PATIENT:	(Last Name)	(First Name)	(M.I.)
ADDRESS:			
TELEPHONE: Home		**TELEPHONE:** Cell	
PHYSICIAN INFO:		**TELEPHONE:**	

APPOINTMENT INFORMATION

Jurisdiction/Agency: City of Fairfax
10455 Armstrong Street, Fairfax, VA 22030

Date:	**Time:**	**Type:** ☐ Initial ☐ Follow-up ☐ Emergency
Total Fee:	**Patient Paid:** $50.00	**Agency Paid:**

Patient Acknowledgement: I understand that the above fee is non-refundable unless I cancel my appointment with at least two working days advance notice to the Dental Clinic and the City of Fairfax Department of Human Services (DHS). I understand I may reschedule my appointment with at least two working days advance notice to the Dental Clinic and the City of Fairfax Department of Human Services (DHS). I give my permission to the City of Fairfax DHS to make this referral to the Northern Virginia Dental Clinic and to share information regarding my needs for dental service and assistance in obtaining these services. I also give permission to the Dental Clinic to obtain information from my physician regarding my medical condition pertinent to my need for dental treatment.

PATIENT SIGNATURE:_____

Referring Worker: Human Services Coordinator **Telephone Number:** 703-385-7894

For Dental Clinic Use:

Patient failed to appear for the appointment scheduled for _____ at _____ a.m. p.m.
Patient rescheduled his/her appointment to _____ at _____ a.m. p.m.
Patient has return appointment for _____ at _____ a.m. p.m. Please collect $_____ for this service.
Patient is in need of a medical clearance/care prior to the dental treatment.
Other, please specify: _____

Dental Clinic Staff: _____ Date: _____

Northern Virginia Dental Clinic
8221 Willow Oaks Corporate Dr.
4th Floor
Fairfax, VA 22031
Telefono: 703-820-7170
Fax: 703-820-7229

Por favor complete con un boligrafo: Date: _____

Nombre del pacciente_____
Apellido Nombre Segundo Nombre

Numero de Seguro Social: _____

Direccion:_____
Calle Apt.

_____
Ciudad Estado Codigo Postal

Telefono: Casa:_____ Trabajo:_____

Doctor Primario: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _Telefono:_ _ _ _ _ _ _ _ _ _ _

Ciudad en la cual vive: ☐ Ciudad de Alexandria ☐ Arlington County ☐ Ciudad de Fairfax
☐ El Condado de Fairfax ☐ Ciudad de Falls Church ☐ Otro (Especificar).____

Reconocimiento del Paciente: Yo entiendo que el pago por el servicio dental no se podra reemoblsar a no ser que yo cancele mi cita por lo menos con **dos dias (de trabajo) de notificacion** a la clinica dental y ala agenda que me refirio. Yo entiendo que puedo pedir un cambio en la fecha de mi cita con por lo menos **dos dias (de trabajo) de anticipacion** a la clinica dental y a la agencia que me refiri6. Yo doy mi permiso a la agencia que me que me esta refiriendo a mandar esta referencia a la Clinica Dental del Norte de Virginia y que la agencia que me esta reflriendo y la clinica dental compartan informacion acerca de mis necesidades dentales y acerca de la asistencia necesaria para obtener los servicios. Tambien le doy permiso a la clinica dental a obtener informacion de rni doctor primario acerca de rni condici6n medica relacionada a mis necesidades de tratamiento dental.

Firma del Paciente_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

……..Esta porcion sera completado por el Dept. of Human Services.……

Appointment Date and Time (Office use) _____ at _____ ○ AM ○ PM
MIDN
☐ Initial Appointment ☐ Follow-up Appointment ☐ Emergency Appointment

Fee: Patient paid: $_____ Agency Sponsor: $ _____ Total: $_____

Referring Agency: City of Fairfax Agency Address: 10455 Armstrong Street Fairfax, VA 22030

Referring Worker: Human Services Coordinator
Telephone: **703-385 7894**

……..Para uso de Ia Clinica D ental……

The above patient failed to appear for the appointment scheduled for _____ at _____ AM PM

The above patient rescheduled his/her appointment to _____ at _____ AM PM

The above patient has a return appointment for this service _____ at _____ AM PM

Please collect $

The above client is in need of medical clearance/care prior to dental treatment.

Other, please specify: _____