**Sliding Fee Scale Application & Eligibility Documentation**

**Date of Application**: **New Patient**: Yes / No

 (circle one)

**Patient Name**: **Patient SSN**:

**Guardian Name**: **Guardian SSN**:

(if patient is under 18 years old)

**Patient Age**: **Patient Date of Birth**:

**Income Verification**

Discounted fees are available for individuals or families whose household income falls within 0% and 200% of the federal poverty guidelines. If you are interested in applying for discounted services, you will need to provide information about your family and your income so your eligibility can be determined.

**Family Size** (includes all family members living within the household):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | 2023 SLIDING FEE SCHEDULE |  |  |
|  |  | BASED ON THE 2023 FEDERAL POVERTY GUIDELINES |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
|  | **GROSS HOUSEHOLD ANNUAL INCOME** |
|  | **Level 1** | **Level 2** | **Level 3** | **Level 4** |  |
|  | No Nominal Fee per visit | Pay $0 nominal fee per visit | Pay $0 nominal fee per visit | Pay $0 nominal fee per visit | ***Patient Is Ineligible For A Discount*** |
| **Sliding Fee Discount** | 100% | 75% | 50% | 25% | 0% |
| **Household size** |   |   |   |   |   |   |   |   |   |   |
| **1** | $1 | $14,580 | $14,581 | $19,391 | $19,392 | $25,515 | $25,516 | $29,159 | $29,160 |   |
| **2** | $1 | $19,720 | $19,721 | $26,228 | $26,229 | $34,510 | $34,511 | $39,439 | $39,440 | **PATIENT IS** |
| **3** | $1 | $24,860 | $24,861 | $33,064 | $33,065 | $43,505 | $43,506 | $49,719 | $49,720 | **INELIGIBLE** |
| **4** | $1 | $30,000 | $30,001 | $39,900 | $39,901 | $52,500 | $52,501 | $59,999 | $60,000 | **FOR A** |
| **5** | $1 | $35,140 | $35,141 | $46,736 | $46,737 | $61,495 | $61,496 | $70,279 | $70,280 | **DISCOUNT** |
| **6** | $1 | $40,280 | $40,281 | $53,572 | $53,573 | $70,490 | $70,491 | $80,559 | $80,560 |   |
| **7** | $1 | $45,420 | $45,421 | $60,409 | $60,410 | $79,485 | $79,486 | $90,839 | $90,840 |   |
| **8** | $1 | $50,560 | $50,561 | $67,245 | $67,246 | $88,480 | $88,481 | $101,119 | $101,120 |   |
| **9** | $1 | $55,700 | $55,701 | $74,081 | $74,082 | $97,475 | $97,476 | $111,399 | $111,400 |   |
| **10** | $1 | $60,840 | $60,841 | $80,917 | $80,918 | $106,470 | $106,471 | $121,679 | $121,680 |   |
| **Percent of Poverty**  | 0%-100% | 101%-133% | 134%-175% | 176%-199% | 200% and up |

To qualify for the Sliding Scale Discount Program, you need to bring at least one document from the following list. The proof of income must be returned within 30 days of application. If you do not provide your proof of income by the due date, you will have to pay full price for services. The Sliding Fee Discount Program begins on the date your proof of income is received at the clinic. If you do not have any of this documentation, PCHS staff can assist you with self-declaring your income.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Income Verification Documents** | **Income Amount** | **Copies Provided** |
| Employment Wages & Earnings | Paystub from work (for last 30 days) |  |  |
| Self-Employed wage documentation (for last 3 months) |  |  |
| Most current Tax Return |  |  |
| Workers Compensation Statement/Stub |  |  |
| Military leave and earnings Statement/Stub |  |  |
| Employer income statement letter |  |  |
| Patient income statement letter  |  |  |
| Benefits | Disability Income Statement/Stub |  |  |
| Current Social Security Statement/Stub |  |  |
| Unemployment Statement/Stub |  |  |
| Other Income | Statement of child support |  |  |
| Most Current Retirement Benefit Statement |  |  |
| Most Current Bank Statement |  |  |
| Other:  |  |  |
|  | **TOTAL:** |  |  |

**Insurance Verification**

Please list any type of health care insurance that you have (Medical Assistance, Minnesota Care, Medicare, or commercial insurance):

If you have insurance please bring your insurance cards to your appointment. If you have already applied for insurance, bring any documents related to your pending application

🞏 I declare the above information is true and I give People's Center Health Services permission to investigate any information on this application. I understand that if my income should change that I am required to notify People’s Center Health Center on my next visit.

**Signature**: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_ \_\_\_\_\_\_\_

*For Office use Only*:

Chart/MRN # Primary Care Provider

Registration and documents reviewed by

Date entered into EMR Date income verification documents received