

## **Sliding Fee Program Application**

The Mission of Main Street Family Medicine is to provide access to quality primary and urgent health care for the residents of Enterprise and surrounding communities regardless of ability to pay. We will take a holistic approach to maintaining a healthy community through education, prevention, and a community networking system. Main Street Family Medicine assures that no patient will be denied healthcare due to their inability to pay. Eligibility for MSFM's Sliding Fee program is determined based upon annual income and household size. A discounted fee will be charged per visit to all eligible patients according to federal income guidelines. This form must be completed every 12 months or any time your financial situation changes. In order to offer you a discount on medical services, it is necessary to ask some personal questions. Your answers will be kept secure and confidential.

| Patient Information                    |             |         |          |           |  |
|--|-------------|---------|----------|-----------|--|
| Patient Name:                          |             |         |          | Date:     |  |
| Date of Birth: Social Security #:      |             |         |          |           |  |
| Address:                               |             |         |          |           |  |
| City:                                  | State:      |         |          |           |  |
| Home Phone:                            | Cell Phone: |         |          |           |  |
| Marital Status: (Circle)               | Single      | Married | Divorced | Separated |  |
| Do you have health insurance? (Circle) |             | Yes     | No       |           |  |
| Insurance Company                      |             |         |          |           |  |
| Policy Number:                         |             |         |          |           |  |

## **Household Size**

|    | Name | Relationship | Date of Birth | SSN |
|----|------|--------------|---------------|-----|
| 1  |      |              |               |     |
| 2  |      |              |               |     |
| 3  |      |              |               |     |
| 4  |      |              |               |     |
| 5  |      |              |               |     |
| 6  |      |              |               |     |
| 7  |      |              |               |     |
| 8  |      |              |               |     |
| 9  |      |              |               |     |
| 10 |      |              |               |     |
| 11 |      |              |               |     |



## **Annual Household Income**

| Source   | Self | Spouse | Other | Total |
|--|------|--------|-------|-------|
| Gross wages, salaries, tips etc.   | \$   | \$     | \$    | \$    |
| Income from business, self-<br>employment and dependents   | \$   | \$     | \$    | \$    |
| Unemployment compensation, workers' compensation, social security, SSI, public assistance, veterans' payments, survivors' benefits, pension or retirement income   | \$   | \$     | \$    | \$    |
| Interest, Investments, Dividends,<br>Rents, Royalties, Income from<br>Estates, Trusts, Educational<br>Assistance, Alimony, Child<br>Support, Assistance from outside<br>the household, and other taxable<br>income | \$   | \$     | \$    | \$    |
| TOTAL  | \$   | \$     | \$    | \$    |

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Main Street Family Medicine if there is a significant change in my income. If acceptance to the sliding fee discount program is obtained under this application, I will comply with all rules and regulations of Main Street Family Medicine. I hereby acknowledge that I have read and understand the foregoing disclosure.

| Signature:                                    | Date:  |
|---|--|
| Print Name:                                   |  |
|   |  |
| Internal Use Only New Applicant               | Renewal Change in Income                           |
| Income Verification (Circle One): Previous Ye | ear Tax Return Payroll Check Stubs Employer Letter |
| Proof of Socia                                | Security Benefits Self-Attestation Other           |
| Total Annual Gross Income:                    |  |
| Eligible Family Size:                         | Approved Discount:                                 |
| Approved by:                                  | Date:  |
| Signed:                                       |  |

## **Income Eligibility Chart 2022**

Main Street Family Medicine will calculate your total annual household income and use that figure to determine your level of discount. The following chart is for reference.

| Aı                 | nnual Income Ti     | hresholds by S | Sliding Fee Dis | scount Pay Cla | ass and % Pov | erty          |
|--------------------|---------------------|----------------|-----------------|----------------|---------------|---------------|
| Poverty<br>Level * | At or Below<br>100% | 100-125%       | 125-150%        | 150-175%       | 175-200%      | Above<br>200% |
| Family             | Nominal Fee         |                |                 | % Charge       |               |               |
| Size               | \$25                | 20% Pay        | 40% Pay         | 60% Pay        | 80% Pay       | 100% Pay      |
| 1                  | \$0 - 13,590        | 13,591 –       | 16,989 –        | 20,386 –       | 23,784 –      | \$27,181+     |
| 1                  |                     | 16,988         | 20,385          | 23,783         | 27,180        |               |
| 2                  | \$0 - \$18,310      | 18,311 –       | 22,889 –        | 27,465 –       | 32,044 –      | \$36,621+     |
| Z                  |                     | 22,888         | 27,465          | 32,043         | 36,620        |               |
| 3                  | \$0 - \$23,030      | 23,031 –       | 28,789 –        | 34,546 –       | 40,304 –      | \$46,061+     |
| 3                  |                     | 28,788         | 34,545          | 40,303         | 46,060        |               |
| 4                  | \$0 – 27,750        | 27,751 –       | 34,689 –        | 41,626 –       | 48,564 –      | \$55,501+     |
| 4                  |                     | 34,688         | 41,625          | 48,563         | 55,500        |               |
| 5                  | \$0 – 32,470        | 32,471 –       | 41,589 –        | 48,706 –       | 56,824 –      | \$64,941+     |
| 5                  |                     | 41,588         | 48,705          | 56,823         | 64,940        |               |
| 6                  | \$0 – 37,190        | 37,191 –       | 46,489 –        | 55,786 –       | 65,084 –      | \$74,381+     |
|                    |                     | 46,488         | 55,785          | 65,083         | 74,380        |               |
| 7                  | \$0 - 41,910        | 41,911 –       | 52,389 –        | 62,866 –       | 73,344 –      | \$83,321+     |
|                    |                     | 52,388         | 62,865          | 73,343         | 83,320        |               |
| 8                  | \$0 – 46,630        | 46,631 –       | 58,289 –        | 69,946 –       | 81,604 –      | \$93,261+     |
| 0                  |                     | 58,288         | 69,945          | 81,603         | 93,260        |               |
| Each Add'l         | \$4,720             | \$5,900        | \$7,080         | \$8,260        | \$9,440       | \$9,440       |

\*Source: HHS 2022 Federal Poverty Guidelines