CENTER FOR HUMAN DEVELOPMENT ı DIVISION OF CLINICAL SERVICES
SLIDING FEE SCALE APPLICATION

2022

It is the policy of Center for Human Development, Division of Clinical Services to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Name of Head of Household:		Place of Employment:
Street:		Phone 1:
City/State:	Zip:	Phone 2 or email:

Please list spouse and dependents under 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	
Attach form with additional dependents and check here			❑

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.	$	$	$	$
Income from business, self-employment, and dependents	$	$	$	$

Source	Self	Spouse	Other	Total
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income	$	$	$	$
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources	$	$	$	$
Total Income	**$**	**$**	**$**	**$**

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information sown above is correct. Additionally, if approved, I accept responsibility for the reduced payment due upon arrival for each service.

Name (Print) _____

Signature _____ Today's Date _____

OFFICIAL USE ONLY

Client Name:

Approved Discount:

Approved by:

Date approved:

Received and Filed by: (Clinic Operations Staff/CORP)

Verification Checklist	YES	NO
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

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SLIDING FEE SCALE FOR OUTPATIENT CLINICAL & PSYCHIATRIC SERVICES

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level	**At or Below 100%**	**125%**	**150%**	**175%**	**200%**	**Above 200%**
Charge						
Family Size	**Nominal Fee ($0)**	**20% pay**	**40% pay**	**60% pay**	**80% pay**	**100% pay**
1	0-$13,590	$16,988 - $20,384	$20,385 - $23,782	$23,783 - $27,179	$27,180 - $30,577	$30,578+
2	0-$18,310	$22,888 - $27,464	$27,465 - $32,042	$32,043 - $36,619	$36,620 - $41,197	$41,198+
3	0-$23,030	$28,788 - $34,544	$34,545 - $40,302	$40,303 - $46,059	$46,060 - $51,817	$51,818+
4	0-$27,750	$34,688 - $41,624	$41,625 - $48,562	$48,563 - $55,499	$55,500 - $62,437	$62,438+
5	0-$32,470	$40,588 - $48,704	$48,705 - $56,822	$56,823 - $64,939	$64,940 - $73,057	$73,058+
6	0-$37,190	$46,488 - $55,784	$55,785 - $65,082	$65,083 - $74,379	$74,380 - $83,677	$83,678+
7	0-$41,910	$52,388 - $62,864	$62,865 - $73,342	$73,343 - $83,819	$83,820 - $94,297	$94,298+
8	0-$46,630	$58,288 - $69,944	$69,945 - $81,602	$81,603 - $93,259	$93,260 - $104,917	$104,918+
For each additional person, add	$4,720	$5,900	$7,080	$8,260	$9,440	$10,620

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