People's Center
CLINICS & SERVICES

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 No Nominal Fee per visit	**Level 2** Pay $0 nominal fee per visit	**Level 3** Pay $0 nominal fee per visit	**Level 4** 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

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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_____