Sliding Fee Discount Application

Jackson's Health

Sliding Fee Discount Application

It is the policy of Jackson's Health 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	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

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

Name (Print)

Signature

Date

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

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		

Financial Assistance Allowance %	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	FPL -Annual Gross Income		**13,590**	**18,310**	**23,030**	**27,750**	**32,470**	**37,190**
100%		up to 200%	27,180	36,620	46,060	55,500	64,940	74,380
80%		201 – 250%	33,975	45,775	57,575	69,375	81,175	92,975
60%		251 – 300%	40,770	54,930	69,090	83,250	97,410	111,570
40%		301 -350%	47,565	64,085	80,605	97,125	113,645	130,165
20%		351 - 400%	54,360	73,240	92,120	111,000	129,880	148,760
0		over 401%						
	Each additional household member add $4,720							

Example: A **one person** household with a gross annual income of $29,000 would receive a Financial Assistance allowance of **80%** as they would be below the 80% income limit of $33,975 but above the 100% income limit of $27,180.

NATIONAL HEALTH SERVICE CORPS

AS A NATIONAL HEALTH SERVICE CORPS SITE,

WE PROMISE TO

- ✓ **Serve all patients**
- ✓ **Offer discounted fees for patients who qualify**
- ✓ **Not deny services based on a person's:**
  - Race
  - Color
  - Sex
  - National origin
  - Disability
  - Religion
  - Sexual orientation
  - Inability to Pay
- ✓ **Accept insurance, including:**
  - Medicaid
  - Medicare
  - Children's Health Insurance Program (CHIP)

This facility is a member of the National Health Service Corps: **NHSC.hrsa.gov.**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration