Lake Superior Community Health Center

Sliding Fee Information Form

Name of Patient_____

Date of Birth _____ Household Size _____

Name (Other family member)	Birthdate	Relationship to patient	Income (Yes or No)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If they have income have you included their income? Yes _____ No _____

Whose income verification have you brought in today? _____

_____

How Often do you get paid? _____ Weekly _____ Bi-Weekly _____ Monthly

Do any other family members need to be on the sliding Fee Program?

Yes _____ No _____

( ) Self ( ) Parent of a Minor ( ) Court Appointed Guardian

_____ _____

Signature Date

OFFICE USE ONLY

Department

- ☐ Medical
- ☐ Dental
- ☐ BH
- ☐ Chiropractic

_____

Signature

Lake Superior Community Health Center
Sliding Fee Discount

We are a Federally Qualified Health Center providing quality medical, dental, and behavioral services. Services are offered regardless of age, gender, race, creed, sexual orientation, disability, immigration status, or national origin.

We are able to offer a sliding fee discount on eligible services to low-income uninsured or underinsured families and individuals. Sliding fee calculations are based on the family/household size and annual gross income. If you have no income or are homeless, our Health Care Access Office will help you to access the sliding fee discount program. Our staff uses the following table to determine your eligibility.

2022 Annual Income Thresholds for Sliding Fee Discount

Nominal Fee (Medical $10) (Dental $25)	Receive 100% discount	Receive 80% discount	Receive 60% discount	Receive 40% discount	Receive 20% discount	Receive 0% discount
Poverty Level	**100%**	**125%**	**150%**	**175%**	**200%**	**Over 200%**
1 family member	**$13,590**	**$16,988**	**$20,385**	**$23,783**	**$27,180**	**>$27,180**
2 family members	**$18,310**	**$22,888**	**$27,465**	**$32,043**	**$36,620**	**>$36,620**
3 family members	**$23,030**	**$28,788**	**$34,545**	**$40,303**	**$46,060**	**>$46,060**
4 family members	**$27,750**	**$34,688**	**$41,625**	**$48,563**	**$55,500**	**>$55,500**
5 family members	**$32,470**	**$40,588**	**$48,705**	**$56,823**	**$64,940**	**>$64,940**
6 family members	**$37,190**	**$46,488**	**$55,785**	**$65,083**	**$74,380**	**>$74,380**
7 family members	**$41,910**	**$52,388**	**$62,865**	**$73,343**	**$83,820**	**>$83,820**
8 family members	**$46,630**	**$58,288**	**$69,945**	**$81,603**	**$93,260**	**>$93,260**

***Sliding Fee Discount Program applies to eligible services provided at Lake Superior Community Health Center (LSCHC) only. If we refer you to another provider, you must check with that provider to determine what discounts apply.**

Sliding Fee Discount Application

If you wish to apply for our sliding fee discount program, you MUST provide proof of gross annual income for all members in your family/household. Annual gross income is verified with one of the following: income tax return, W-2 form, two most recent pay stubs, employer letter, unemployment check stub or letter, social security award letter, or a letter from our Health Care Access Office. Adjusted gross income (Line 37 on Federal tax return, Box D on Minnesota return, or Line 1 on Wisconsin return) is used when an income tax return is presented as proof of income.

Name: _____

Address: _____

_____

Phone Number: _____

Number of members in family/household: _____

Total Annual Income for Family/Household: $ _____

Name and Date of Birth of Dependent Children to be covered under this application: _____

_____

_____

I hereby certify that this information is, to the best of my knowledge, true and correct. I further agree to notify Lake Superior Community Health Center of any changes in this information within ten (10) days of such a change. I understand that I must re-apply annually to maintain my eligibility.
I am also aware that this information is based upon Federal Poverty Guidelines. Nominal fee is requested at time of services. All remaining balances will be billed to you. If you are unable to make monthly payments, please speak with our billing department to make other payment arrangements.

X _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

TO BE COMPLETED BY LSCHC STAFF:

☐ *Patient is eligible for a _____ % sliding fee discount and income has been verified.*

☐ *Patient does not qualify for a sliding fee discount.*

_____ _____

Verified By *Date*