To apply for the sliding fee, please have the patient, or the guardian complete the Sliding Fee Discount Application and provide their most recent pay stubs for the last 30 days, current personal income tax return or an unemployment benefit statement. Please provide us with a copy of any denial letters from Missouri, Kansas or Oklahoma Medicaid if applicable. If you have Medicaid coverage from another state, please provide that information to the front desk. This application should be updated on an annual basis.

SLIDING FEE SCALE - Based on 2020 Federal Poverty Guidelines

***If actual charges are less than amounts shown, patient pays lesser amount.**

Federal Poverty Level	<100% FPL	101-133% FPL	134-166% FPL	167-199% FPL	>200% FPL
Slide Level	A	B	C	D	E
Medical Professional Services Sliding Fee					
Patient Pays*	$25	$50	$75	$100	100% of charges

Persons in Household	Federal Poverty Guidelines (Monthly)				
	A -100%	B-133%	C-138%	D -150%	E ->200%
1	$ 1,063	$ 1,329	$ 1,595	$ 2,126	$ 2,127
2	$ 1,437	$ 1,796	$ 2,156	$ 2,874	$ 2,875
3	$ 1,810	$ 2,263	$ 2,715	$ 3,620	$ 3,621
4	$ 2,183	$ 2,729	$ 3,275	$ 4,366	$ 4,367
5	$ 2,557	$ 3,196	$ 3,836	$ 5,114	$ 5,115
6	$ 2,930	$ 3,663	$ 4,395	$ 5,860	$ 5,861
7	$ 3,303	$ 4,129	$ 4,955	$ 6,606	$ 6,607
8	$ 3,677	$ 4,596	$ 5,516	$ 7,354	$ 7,355

Add $373 for each person over 8

Persons in Household	48 Contiguous States and D.C. Poverty Guidelines (Annual)				
	A-100%	B-133%	C-138%	D-150%	E->200%
1	$12,760	$15,950	$19,140	$25,520	$25,521
2	$17,240	$21,550	$25,860	$34,480	$34,481
3	$21,720	$27,150	$32,580	$43,440	$43,441
4	$26,200	$32,750	$39,300	$52,400	$52,401
5	$30,680	$38,350	$46,020	$61,360	$61,361
6	$35,160	$43,950	$52,740	$70,320	$70,321
7	$39,640	$49,550	$59,460	$79,280	$79,281
8	$44,120	$55,150	$66,180	$88,240	$88,241

Add $4,480 for each person over 8

Application for Sliding Fee Discounts

Today's date: _____

Head of household:

_____ _____ _____
Last name First name MI

_____ _____
Street address Date of birth

_____ _____ _____ _____
City State Zip Home phone no.

Head of household gross monthly income: $_____

Other family members:

Name	Date of birth	Gross monthly income
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

For additional family member(s) please use the back of this form.

Total family gross monthly income: $_____

Total family members: _____

Please include with application proof of income documents, ie. Pay Stubs, prior year tax returns, statement of sustainability, social security determination letter and any Medicaid denial letters.

By signing this form, I attest to the truthfulness and completeness of all information requested.

_____ _____
Signature Date

DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)

Proof of income documents received:

[ ] Pay stubs [ ] Prior year tax returns [ ] Social Security determination letter

[ ] Statement of sustainability [ ] Medicaid Denial letter

A copy of each document must be attached to this application.

Eligible for discount of: _____% Beginning: _____ Ending: _____

_____ _____
Signature of staff Date

Statement of Sustainability

Please fill out this statement of sustainability if you cannot provide any proof of income. Please indicate how persons with no income are meeting their day to day basic living needs. This will enable Pediatric Associates of Southwest Missouri, LLC. to process your discount application.

By signing this form, I attest to the truthfulness and completeness of all information requested.

Signature _____ Date _____