Name: _____ Date of Birth: _____

Total gross annual salary: _____ (Must attach copies of latest check stubs or W-2's)

Please place a check mark by the following which may apply to you, your spouse or your children and give specific amounts

Application for Slide Scale Fee Privileges to retain sliding scale fee privileges PROOF OF INCOME MUST BE SUPPLIED WITHIN 5 DAYS OF THIS APPLICATION. (Example of proof of income includes but not limited to: Recent pay stub for all working members and evidence of other income, current award letter or printout from the Social Security Administration, alimony or child support, a statement on employer letterhead stating average hours worked a week and the pay rate, or a recent bank statement.) *If proof of income is not received or you refuse to supply this information within this time, you will be responsible for 100% of the bill.* Please complete the following household information: Do you or anyone residing in your household receive any of the following?

		Yes	No	Amount			Yes	No	Amount
A	Employment				K	Social Security for spouse, children or others			
B	Unemployment				L	Food Stamps			
C	Worker's Compensation				M	Any regular support for anyone not living with you			
D	Strike Benefits				N	Government Employee Pension			
E	Veteran's Benefits				O	Private insurance and/or regular insurance annuity payments			
F	Job Training Funds				P	Dividends			
G	Alimony				Q	Interest Payments			
H	Child Support				R	Rental Payments			
I	Military Family Allotments				S	Royalties			
J	AFDC				T	Income from estate trusts			

Please list the name of each member of your household below (If not enough space, please use back)

Name	Date of Birth	Income	Weekly, Bi-Weekly, Bi-Monthly, Monthly

I certify that I have read or have had read to me the above questionnaire and that all of the information is correct. I understand that failure to make full disclosure of my true income is an act of fraud and can be punishable by either a fine or imprisonment according to federal law.

Patient/Guardian Signature _____ Today's Date

2024 Sliding Scale Discounts

You may be eligible for **DISCOUNTED SERVICES** —even with private insurance!

Arbor Health Clinics offer discounted services to **ALL** who qualify. Find out if you are eligible on the scale below.

How Many People in Your Household?	INCOME LEVEL Pay only $20	INCOME LEVEL Pay 25%	INCOME LEVEL Pay 50%	INCOME LEVEL Pay 75%	INCOME LEVEL Pay 100%
1	$0 – $15,060.00	$15,060.01 – $20,029.80	$20,029.81 – $24,999.60	$24,999.61 – $30,120.00	$30,120.01 +
2	$0 – $20,440.00	$20,440.01 – $27,185.20	$27,185.21 – $33,930.40	$33,930.41 – $40,880.00	$40,880.01 +
3	$0 – $25,820.00	$25,820.01 – $34,340.60	$34,340.61 – $42,861.20	$42,861.21 – $51,640.00	$51,640.01 +
4	$0 – $31,200.00	$31,200.01 – $41,496.00	$41,496.01 – $51,792.00	$51,792.01 – $62,400.00	$62,400.01 +
5	$0 – $36,580.00	$36,580.01 – $48,651.40	$48,651.41 – $60,722.80	$60,722.81 – $73,160.00	$73,160.01 +
6	$0 – $41,960.00	$41,960.01 – $55,806.80	$55,806.81 – $69,653.60	$69,653.61 – $83,920.00	$83,920.01 +
7	$0 – $47,340.00	$47,340.01 – $62,962.20	$62,962.21 – $78,584.40	$78,584.41 – $94,680.00	$94,680.01 +
8	$0 – $52,720.00	$52,720.01 – $70,117.60	$70,117.61 – $87,515.20	$87,515.21 – $105,440.00	$105,440.01 +
Over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8	Add $5,380 for each person over 8

Once qualified, you must show us valid proof of income to receive your discounts.
Accepted documents: Tax Return, Recent Check Stub, Bank Statement, Social Security Letter or Food Stamp Award Letter. Please fill out a Sliding Scale Form available at the front desk. **If you have questions, just ask us!**

Based on 2024 Poverty Guidelines, U.S. Health & Human Services
https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Our Care Coordinators

Our Arbor Family Health Care Coordinators are here to answer ALL of your questions!
We can help you:

- Apply for Medicaid/Medicare
- Apply for SNAP benefits
- Section 8 Affordable Housing
- Assistance with Transportation
- Obtain a cell phone
- Prepare you for a job interview
- Network with local job opportunities
- Assist you in learning how to be a successful employee

Give us a call today and ask to speak with a Care Coordinator!

1-888-711-3785

ARBOR FAMILY HEALTH