Sliding Fee Scale Application

Patient Information			Today's Date: / /	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -	Do you have insurance? (circle one) Yes No		
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTICE: To comply with federal regulations, in order to give you a discount on medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly federal income tax return, a copy of your most recent W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount, if any.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform St. Petersburg Pediatrics if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of St. Petersburg Pediatrics. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:________________________ Name (Print):____

Signature:____

Sliding Fee Scale

Family Size	FPL based on Annual Income	100% FPL 100% Discount	150% FPL 80% Discount	200% FPL 60% Discount	300% FPL 40% Discount	400% FPL 20% Discount
1	$ 15,650.00	$ 15,650.00	$ 23,475.00	$ 31,300.00	$ 46,950.00	$ 62,600.00
2	$ 21,150.00	$ 21,150.00	$ 31,725.00	$ 42,300.00	$ 63,450.00	$ 84,600.00
3	$ 26,650.00	$ 26,650.00	$ 39,975.00	$ 53,300.00	$ 79,950.00	$ 106,600.00
4	$ 32,150.00	$ 32,150.00	$ 48,225.00	$ 64,300.00	$ 96,450.00	$ 128,600.00
5	$ 37,650.00	$ 37,650.00	$ 56,475.00	$ 75,300.00	$ 112,950.00	$ 150,600.00
6	$ 43,150.00	$ 43,150.00	$ 64,725.00	$ 86,300.00	$ 129,450.00	$ 172,600.00
7	$ 48,650.00	$ 48,650.00	$ 72,975.00	$ 97,300.00	$ 145,950.00	$ 194,600.00
8	$ 54,150.00	$ 54,150.00	$ 81,225.00	$ 108,300.00	$ 162,450.00	$ 216,600.00
For Each Add'l Person Add	$ 5,500.00	$ 5,500.00	$ 8,250.00	$ 11,000.00	$ 16,500.00	$ 22,000.00

*All income levels above represent adjusted gross income levels.

Note: * Based on 2023 Federal Poverty Guidelines

The income ceiling for the minimum fee pay class is equal to the federal poverty level.