DOCUMENTED VERIFICATION OF INCOME/FAMILY SIZE

DATE OF SERVICE____________

Patient Sticker

(Attach copies of proof of income, such as paycheck stubs, income tax returns, etc.)

Always make copies, never hand over originals you may need for use later.

ANNUAL INCOME________________________

FAMILY SIZE________________________

A PREGNANT WOMAN WILL COUNT AS TWO IN THE FAMILY

SLIDING FEE________________________

I certify that the information I have provided is correct, to the best of my knowledge. I understand that I will be held responsible for any consequences (e.g. payments, fines, legal action, etc.) resulting from intentionally providing false or misleading information.	Signature of person responsible for this account Date

WCCHC Sliding Fee Scale 2022. All income categories are from the 2022 Federal Poverty Guidelines

Family Size	Level 1 Slide Medical or BH* $25 Flat Fee Dental Schedule 1 Fees: $30 Schedule 2 Fees: $150	Level 2 Slide Medical or BH* $30 Flat Fee Dental 20% of Full Fee	Level 3 Slide Medical or BH* $45 Flat Fee Dental 40% of Full Fee	Level 4 Slide Medical or BH* $65 Flat Fee Dental 60% of Full Fee	Level 5 Slide Medical or BH* $85 Flat Fee Dental 80% of Full Fee	Level 6 No Discount Full Fee
1	$0 $13,590	$13,591 $16,988	$16,989 $20,385	$20,386 $23,783	$23,784 $27,180	$27,181
2	$0 $18,310	$18,311 $22,888	$22,889 $27,465	$27,466 $32,043	$32,044 $36,620	$36,621
3	$0 $23,030	$23,031 $28,788	$28,789 $34,545	$34,546 $40,303	$40,304 $46,060	$46,061
4	$0 $27,750	$27,751 $34,688	$34,689 $41,625	$41,626 $48,563	$48,564 $55,500	$55,501
5	$0 $32,470	$32,471 $40,588	$40,589 $48,705	$48,706 $56,823	$56,824 $64,940	$64,941
6	$0 $37,190	$37,191 $46,488	$46,489 $55,785	$55,786 $65,083	$65,084 $74,380	$74,381
7	$0 $41,910	$41,911 $52,388	$52,389 $62,865	$62,866 $73,343	$73,344 $83,820	$83,821
8	$0 $46,630	$46,631 $58,288	$58,289 $69,945	$69,946 $81,603	$81,604 $93,260	$93,261
For each additional family member	$4,720	$5,900	$7,080	$8,260	$9,440	
CHC Target Population	Up to and Including 100% of poverty	To 125% of poverty	To 150% of poverty	To 175% of poverty	Up to and Including 200% of poverty	Over 200% of poverty

***The Nominal fee is $25 for Medical and Behavioral Health Services. The Nominal fee is $30 for Schedule 1 Dental services per visit, and the Nominal fee of $150 for Schedule 2 Dental services per visit. Additional Behavioral Health grants and adjustments may apply.**

Interviewer's Signature ________________________

PROOF OF INCOME WORKSHEET **(for employee use ONLY)**

Patient name ____________________________________

Number of people in family____________________

Enter gross amount _________________

____

____

____

If they get paid weekly take gross amount add it together, total amount divided by 4 then times 52.

Total amount _________________

Amount divided by 4 ____________

Amount times 52 ______________

This amount is your yearly income

If they get paid biweekly take gross amount add it together, total amount divided by 2 then times 26.

Total amount _________________

Amount divided by 2 ____________

Amount times 26 ______________

This amount is your yearly income

If they get paid bimonthly take gross amount add it together, total amount divided by 2 then times 24.

Total amount _________________

Amount divided by 2 ____________

Amount times 24 ______________

This amount is your yearly income

Completed By________________________ Date______________________________

Definition of Family: One or more adults and children related by blood or law and residing in the same household. Where adults other than the spouse reside together each should be considered a separate family.

1. The Clinic uses the Federal Poverty Income level guidelines to determine the discount the patient will receive based on their income and family size.
2. If a patient wishes to be evaluated for the Clinic's sliding fee scale, they MUST bring information regarding their household income with them when they come to their initial appointment. Patient will be charged full fee until proof of income is provided.
3. To continue to qualify for sliding fees, the patient will need to bring income information once a year.

ACCEPTABLE FORMS OF PROOF OF INCOME:

1. Two pay stubs within the last thirty days
2. Last year's tax return
    a. Gross income before deductions for income taxes, employees' social security taxes, insurance premiums, etc...
3. Other income records
    a. (i.e. Employment Verification Statement, Verification of Support Statement; Self Employment Record; "0" Income Affidavit)

Income figured on base pay