SLIDING FEE SCALE APPLICATION

Evergreen Health assures that no patient will be denied healthcare due to their inability to pay. Eligibility for Evergreen Health's Sliding Fee program is determined based upon annual income and household size. A discounted fee will be charged per visit to all eligible patients according to income guidelines. This form must be completed every 12 months or if your financial situation changes.

PATIENT INFORMATION

Patient Name: _____ Date: _____

Preferred Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact Phone: ◯ Home ◯ Cell

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated

Do you have health insurance? ◯ Yes ◯ No

Insurance Company: _____

Policy Number: _____

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HOUSEHOLD SIZE

NAME	DATE OF BIRTH

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.	$	$	$	$
Income from business, self-employment, and dependents	$	$	$	$
Unemployment compensation, workers' compensation, social security, SSI, public assistance, veterans' payments, survivors benefits, pension or retirement income	$	$	$	$
Interest, investments, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other taxable income	$	$	$	$
TOTAL	$	$	$	$

Note: Noncash benefits (such as food stamps and housing subsidies) do not count as income. Copies of tax returns, pay stubs, or other information verifying income may be required before assistance is approved.

Indicate if this is a self-declaration of income:

◯ Self-declaration of income

◯ Self-declaration of zero income (must complete corresponding form)

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INCOME ELIGIBILITY CHART 2021

Evergreen Health staff will calculate your total annual household income and use that figure to determine your level of discount. The following chart is for your reference.

Annual Income Thresholds by Sliding Fee Discount Pay Class and % Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Full Discount	% CHARGE				
		20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$12,880	$12,881-$16,100	$16,101-$19,320	$19,321-$22,540	$22,541-$25,760	$25,761+
2	0-$17,420	$17,421-$21,775	$21,776-$26,130	$26,131-$30,485	$30,486-$34,840	$34,841+
3	0-$21,960	$21,961-$27,450	$27,451-$32,940	$32,941-$38,430	$38,431-$43,920	$43,921+
4	0-$26,500	$26,501-$33,125	$33,126-$39,750	$39,751-$46,375	$46,376-$53,000	$53,001+
5	0-$31,040	$31,041-$38,800	$38,801-$46,560	$46,561 $54,320	$54,321-$62,080	$62,081+
6	0-$35,580	$35,581-$44,475	$44,476-$53,370	$53,371-$62,265	$62,266-$71,160	$71,161+
7	0-$40,120	$40,121-$50,150	$50,151-$60,180	$60,181-$70,210	$70,211-$80,240	$80,241+
8	0-$44,660	$44,661-$55,825	$55,826-$66,990	$66,991-$78,155	$78,156-$89,320	$89,321+
9	0-$49,200	$49,201-$61,500	$61,501-$73,800	$73,801-$86,100	$86,101-$98,400	$98,401
10	0-$53,740	$53,741-$67,175	$67,176-$80,610	$80,611-$94,045	$94,046-$107,480	$107,481

Source: HHS 2021 Federal Poverty Guidelines

I CERTIFY THAT THE HOUSEHOLD SIZE AND INCOME INFORMATION SHOWN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF ANY OF THE INFORMATION I HAVE SUBMITTED IS DETERMINED TO BE FALSE, I MAY NO LONGER BE ELIGIBLE FOR THE SLIDING FEE DISCOUNT. SHOULD THIS OCCUR, I MAY BE RESPONSIBLE FOR ANY OUT OF POCKET EXPENSES.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Approved Sliding Fee Discount:

- ○ Full Discount
- ○ 20% charge
- ○ 40% charge
- ○ 60% charge
- ○ 80% charge
- ○ Patient is ineligible

Comments:

VERIFICATION CHECKLIST:

- ☐ IDENTIFICATION: _____
- ☐ PROOF OF ADDRESS: _____
- ☐ PROOF OF INCOME: _____
- ☐ INSURANCE INFORMATION: _____

Approved By: _____ Date: _____