Sliding Fee Discount Program Application

The LSS Health Center is a Federally Qualified Health Center that is able to offer a discount on certain services based on a household's income and size. Sliding fee calculations are determined by using an applicant's total household annual income and are based on the most recent Federal Poverty Guidelines (table displayed on reverse side) to determine your eligibility.

If you wish to qualify for the sliding fee, you must show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please provide a brief, written statement explaining how you provide basic life essentials, food, and shelter.

Applicants should provide a copy of the following documents, if applicable:

- Previous year's Federal Tax Return, W-2's or 1099's (Income will come from total income line)
- Most recent pay stubs spanning four weeks
- Social Security or Pension Income
- Public assistance award letters for each adult age 18 and over living in the household.
- Unemployment compensation

Your household discount will be assessed once per year. You must reapply for the Sliding Fee discount and provide updated income documentation at this time.

Name: _____ Date of Birth: _____

Family Size (number of family members living in your household): _____

List name(s) and date(s) of birth of family members/individuals living in your household or individuals whom you are financially responsible:

_____

_____

_____

Address: _____

Phone: _____ Do you have insurance? (Check one) YES ☐ NO ☐

If yes, please provide Medical Plan Name: _____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I understand that I must re-qualify annually to maintain my eligibility. I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly. If you are unable to make payment at the time of service, please discuss with a member of the LSS Health Center staff to request a Financial Hardship Waiver.

FOR INTERNAL USE ONLY

Annual Gross Income_____

Patient is eligible for sliding fee discount category_____

☐ Proof of income verified

☐ Patient refused to complete

☐ Patient does not qualify for sliding fee

Verified by_____ Date_____

_____ _____

Signature Date

Sliding Fee Scale

Based on Federal Register 2026 Poverty Guidelines

Family Size	Income Measure	Category A	Category B	Category C	Category D	Category E
% of Federal Poverty Income Level		Up to 100%	100.01%-149.99%	150.00%-174.99%	175.00%-199.99%	200.00%+
Patient Fee:						
Medical and BH		$5.00	$10.00	$20.00	$30.00	$100.00
Vision		$5.00	$10.00	$20.00	$30.00	$100.00
Dental		$10.00	$20.00	$30.00	$40.00	$100.00
Lab Work		$10.00	$15.00	$20.00	$25.00	$30.00
Pharmacy **Plus the cost of medication*		$0.00	$2.00	$4.00	$6.00	$8.00
1	Annual Income	$0 – $15,960	$15,961 – $23,940	$23,941- $27,930	$27,931– $31,920	$31,921 +
2	Annual Income	$0 – $21,640	$21,641 – $32,460	$32,461 – $37,870	$37,871 – $43,280	$43,281 +
3	Annual Income	$0 – $27,320	$27,321 – $40,980	$40,981– $47,810	$47,811 –$54,640	$54,641 +
4	Annual Income	$0 – $33,000	$33,001 – $49.500	$49,501 – $57,750	$57,751 – $66,000	$66,001 +
5	Annual Income	$0 – $38,680	$38,681 – $58,020	$58,021 – $67,690	$67,691 – $77,360	$77,361+
6	Annual Income	$0 – $44,360	$44,361 – $66,540	$66,541 – $77,630	$77,631 – $88,720	$88,721 +
7	Annual Income	$0 – $50,040	$50,041 – $75,060	$75,061 – $87,570	$87,571 – $100,080	$100,081 +
8	Annual Income	$0 – $55,720	$55,721 – $83,580	$83,581– $97,510	$97,511– $111,440	$111,441 +
Each additional family member		+ $5,140	+ $5,140	+ $7,710	+ $8,995	+ $10,280

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