

SLIDING FEE AND PATIENT ASSISTANCE PROGRAM



Patient Name: _____ Date of Birth: _____

2026 Federal Poverty Level (FPL) – Place a checkmark in the corresponding range below								
Family Size	1	2	3	4	5	6	7	8
100%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$15,960.00	\$21,640.00	\$27,320.00	\$33,000.00	\$38,680.00	\$44,360.00	\$50,040.00	\$55,720.00
75%	\$15,961.00	\$21,641.00	\$27,321.00	\$33,001.00	\$38,681.00	\$44,361.00	\$50,041.00	\$55,721.00
	\$21,227.00	\$28,781.00	\$36,336.00	\$43,890.00	\$51,444.00	\$58,999.00	\$66,553.00	\$74,108.00
50%	\$21,228.00	\$28,782.00	\$36,337.00	\$43,891.00	\$51,445.00	\$59,000.00	\$66,554.00	\$74,109.00
	\$26,494.00	\$35,922.00	\$45,351.00	\$54,780.00	\$64,209.00	\$73,638.00	\$83,066.00	\$92,495.00
25%	\$26,495.00	\$35,923.00	\$45,352.00	\$54,781.00	\$64,210.00	\$73,639.00	\$83,067.00	\$92,496.00
	\$31,920.00	\$43,280.00	\$54,640.00	\$66,000.00	\$77,360.00	\$88,720.00	\$100,080.00	\$111,440.00
0%	\$31,921.00	\$43,281.00	\$54,641.00	\$66,001.00	\$77,361.00	\$88,721.00	\$100,081.00	\$111,441.00
	or more	or more	or more	or more	or more	or more	or more	or more

*To continue to provide the community with discount services, we are required to report the statistics of the income level of our community to the HRSA programs. This information is reported discreetly, and no patient information is included. We ask that even if you do not want to apply for our Sliding Fee Discount Program, you provide us with the income information for your household.

**The percentages listed reflect the portion of charges the patient is responsible for after discount is applied.

Sliding Fee Application

I decline to apply for the Sliding Fee Discount Program I am applying for Sliding Fee

Are you currently employed?	Yes	No	Is anyone else in the household employed?	Yes	No
Does anyone in your household receive state or federal benefits (such as cash assistance, SNAP, SSI/SSDI, unemployment, etc.)?	Yes	No	If yes, what programs?	_____	
Do you currently have health insurance through an employer, spouse, parent, Medicaid, Medicare, Marketplace, or another source?	Yes	No	If yes, what is the insurance company name:	_____	
			Policy Number:	_____	
			Member Name:	_____	
The number of household members living in my home (including those related by birth, marriage, or adoption and/or who share living expenses) is:	_____		Total Monthly Household Income (all money received before taxes by all household members, including wages, self-employment income, Social Security, SSI/SSDI, unemployment, child support, alimony, and other regular income):	_____	

Attestation & Authorization

I certify that the household size, income, and insurance information I provided is true and complete.

I understand this information may be used to determine eligibility for the Sliding Fee Program, other patient assistance programs, and funding sources including federal, state, local, and ADAMH Board programs, as well as required HRSA UDS reporting.

I agree to provide proof of income and to update my information annually or if changes occur. I understand that false or incomplete information may result in loss of discounts and full responsibility for charges.

I authorize Hopewell Health Centers to release medical and financial information needed to process insurance claims and determine eligibility for assistance. I authorize payment of benefits directly to Hopewell Health Centers. This serves as my signature on file for assignment of benefits, including claims submitted on the CMS-1500.

Patient/Guardian Name (Printed): _____ Signature: _____

Relationship to Patient (if applicable): _____ Date: _____

SLIDING FEE AND PATIENT ASSISTANCE PROGRAM



Hopewell Health Centers offers a Sliding Fee and Patient Assistance Program to help reduce out-of-pocket costs for eligible patients. **Patients may qualify whether they have insurance or do not have insurance.** The sliding fee discount applies to charges for covered services after insurance payments are applied.

Reduced charges are available for individuals and families with gross household income at or below 200% of the Federal Poverty Guidelines listed below and are based on household size. No sliding fee discount may be provided to patients whose household income exceeds 200% of the Federal Poverty Level.

To see if you qualify, please review the income guidelines below.

If you wish to apply for the Sliding Fee and Patient Assistance Program, you **MUST** provide proof of gross annual income for all members of your household. Please see the back of this form for Proof of Income Requirements and a list of acceptable documents.

**No patient will be denied services due to inability to pay. Patients are required to provide accurate and complete financial information to determine eligibility for discounts or assistance. Refusal to provide required financial information does not prevent access to care but may result in charges being assessed at full fee.*

Proof of Income Requirements

To process your application, please provide proof of **gross income (before taxes)** for all household members.

You may provide:

- Most recent pay stub (last 30 days)
- Last year's W-2 or tax return
- Social Security or SSI/SSDI award letter
- Unemployment statement
- Child support or alimony documentation
- Pension or retirement statement
- SNAP or other benefit award letter
- Written statement of no income (if applicable)

If you have no income, please notify staff. Additional documentation may be required.

Important Information

- Discounts are based on household size and income up to 200% of the Federal Poverty Level.
- Patients over 200% of the Federal Poverty Level do not qualify for sliding fee discounts.
- Patients with insurance may still qualify for sliding fee discounts on remaining balances.
- Income information is collected to meet HRSA reporting requirements. No patient-identifying information is reported.
- Eligibility must be renewed at least once every 12 months or sooner if income or household size changes.

Additional Assistance Programs

As a Federally Qualified Health Center (FQHC), Hopewell Health Centers receives funding from federal, state, and local programs to support patient care.

Depending on eligibility and available funds, assistance may include support from:

- Federal grant programs
- State-funded programs
- Local funding sources
- The ADAMH Board
- Other community-based grants

Eligibility requirements vary by program. Approval is not guaranteed and is based on funding availability and program guidelines.