Sliding Fee Scale Eligibility Form

Patient Name:________________________ DOB:________________ Acct #:____________

Discounted services rendered at Generations may be available to you, based on the income information and Family size you provide below.

Please fill out question 1 and 2 below **OR** use the chart below to provide your household income.

1) What is your Family Size? ____________ 2) Please provide your monthly income:________________

OR

Federal poverty guidelines are updated annually** ***Last updated 1/19/2022

Find your family size and circle the monthly income range for your household

Family Size	SFS Level **A** (0% - 100%) Income **equal to or less than** Monthly	SFS Level **B** (101% - 125%) Income **equal to or less than** Monthly	SFS Level **C** (126% - 150%) Income **equal to or less than** Monthly	SFS Level **D** (151% - 200%) Income **equal to or less than** Monthly	SFS Level **E** (201% and more) Income **EQUAL TO OR GREATER** than Monthly
1	$1,132	$1,415	$1,698	$2,265	$2,266
2	$1,525	$1,907	$2,288	$3,051	$3,052
3	$1,919	$2,398	$2,878	$3,838	$3,839
4	$2,312	$2,890	$3,468	$4,625	$4,626
5	$2,705	$3,382	$4,058	$5,411	$5,412
6	$3,099	$3,873	$4,648	$6,198	$6,199
7	$3,492	$4,365	$5,238	$6,985	$6,986
8	$3,885	$4,857	$5,828	$7,771	$7,772

Family member name	**Date of birth**

By Signing below, I hereby verify that the above information is true and accurate. I acknowledge that this is a federally funded program and if false information is given, I may be disqualified from the sliding fee scale discount program. Based on the information above, if I qualify for the discount program, I understand that my nominal fee payment is due at every visit. I also acknowledge that any incurred dental lab fees are not included in my nominal fee discount.

Printed Name ____________ Signature ____________ Date ____________