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 1/23/2023

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	$ 1,215	$ 1,518.75	$ 1,822.50	$ 2,430	$ 2,430.08
2	$ 1,643	$ 2,054.17	$ 2,465.00	$ 3,287	$ 3,286.75
3	$ 2,072	$ 2,589.58	$ 3,107.50	$ 4,143	$ 4,143.42
4	$ 2,500	$ 3,125.00	$ 3,750.00	$ 5,000	$ 5,000.08
5	$ 2,928	$ 3,660.42	$ 4,392.50	$ 5,857	$ 5,856.75
6	$ 3,357	$ 4,195.83	$ 5,035.00	$ 6,713	$ 6,713.42
7	$ 3,785	$ 4,731.25	$ 5,677.50	$ 7,570	$ 7,570.08
8	$ 4,213	$ 5,266.67	$ 6,320.00	$ 8,427	$ 8,426.75

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 _____