Sliding Fee Scale Eligibility Form 2024

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

Provide Annual Income range below:

Federal poverty guidelines are updated annually** ***Last updated 2/1/2024

Find your family size and circle the annual income range for your household								
Family Size	**<100%**	**101-125%**		**126-150%**		**151-200%**		**200%+**
	Income equal to or less than	**Annual Income range**		**Annual Income range**		**Annual Income range**		**Annual Income equal to or greater than**
		From	**To**	**From**	**To**	**From**	**To**	**At least**
1	$ 15,060	$ 15,061	$ 18,825	$ 18,826	$ 22,590	$ 22,591	$ 30,120	$ 30,121
2	$ 20,440	$ 20,441	$ 25,550	$ 25,551	$ 30,660	$ 30,661	$ 40,880	$ 40,881
3	$ 25,820	$ 25,821	$ 32,275	$ 32,276	$ 38,730	$ 38,731	$ 51,640	$ 51,641
4	$ 31,200	$ 31,201	$ 39,000	$ 39,001	$ 46,800	$ 46,801	$ 62,400	$ 62,401
5	$ 36,580	$ 36,581	$ 45,725	$ 45,726	$ 54,870	$ 54,871	$ 73,160	$ 73,161
6	$ 41,960	$ 41,961	$ 52,450	$ 52,451	$ 62,940	$ 62,941	$ 83,920	$ 83,921
7	$ 47,340	$ 47,341	$ 59,175	$ 59,176	$ 71,010	$ 71,011	$ 94,680	$ 94,681
8	$ 52,720	$ 52,721	$ 65,900	$ 65,901	$ 79,080	$ 79,081	$ 105,440	$ 105,441

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 _____