**Sliding Fee Scale Eligibility Form 2025**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 2/1/2025\*\**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | $15,650 | $15,651 | $19,563 | $19,564 | $23,475 | $23,476 | $31,300 | $31,301 |
| **2** | $21,150 | $21,151 | $26,438 | $26,439 | $31,725 | $31,726 | $42,300 | $42,301 |
| **3** | $26,650 | $26,651 | $33,313 | $33,314 | $39,975 | $39,976 | $53,300 | $53,301 |
| **4** | $32,150 | $32,151 | $40,188 | $40,189 | $48,225 | $48,226 | $64,300 | $64,301 |
| **5** | $37,650 | $37,651 | $47,063 | $47,064 | $56,475 | $56,476 | $75,300 | $75,301 |
| **6** | $43,150 | $43,151 | $53,938 | $53,939 | $64,725 | $64,726 | $86,300 | $86,301 |
| **7** | $48,650 | $48,651 | $60,813 | $60,814 | $72,975 | $72,976 | $97,300 | $97,301 |
| **8** | $54,150 | $54,151 | $67,688 | $67,689 | $81,225 | $81,226 | $108,300 | $108,301 |

|  |  |
| --- | --- |
| **Family member name** | **Date of birth** |
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**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.**

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|  |  |  |  |  |
| Printed Name |  | Signature |  | Date |