SLIDING FEE SCALE QUALIFICATION FORM

Patient Full Name: _____ Date of Birth:_____

Responsible Party: _____

COMBINED GROSS INCOME OF ALL FAMILY MEMBERS IN HOUSEHOLD VERIFIED BY:

_____ Paycheck Stubs for past month
_____ W-2 form for last tax year
_____ Last income tax return
_____ Unemployment benefit verification
_____ Social Security benefit verification
_____ Number in Household

MY SLIDING SCALE PLACEMENT PERCENTAGE _____

ANNUAL INCOME VERIFICATION EXPIRES ON_____

Yearly

Family Unit Size	Minimum Fee	20% pay	40% pay	60% pay	80% pay	100% pay
Poverty	100%	125%	150%	175%	200%	Over 200%
1	11,170	13,963	16,755	19,548	22,340	>22,340
2	15,130	18,913	22,695	26,478	30,260	>30,260
3	19,090	23,863	28,635	33,408	38,180	>38,180
4	23,050	28,813	34,575	40,338	46,100	>46,100
5	27,010	33,763	40,515	47,268	54,020	>54,020
6	30,970	38,713	46,455	54,198	61,940	>61,940
7	34,930	43,663	52,395	61,128	69,860	>69,860
8	38,890	48,613	58,335	68,058	77,780	>77,780

The 2012 federal poverty guideline increases by $3,960 for each additional family member.

Monthly

Family Unit Size	Minimum Fee	20% pay	40% pay	60% pay	80% pay	100% pay
Poverty	100%	125%	150%	175%	200%	201%
1	931	1164	1,396	1,629	1,862	>1862
2	1,261	1576	1,891	2,206	2,522	>2522
3	1,591	1989	2,386	2,784	3,182	>3182
4	1,921	2401	2,881	3,361	3,842	>3842
5	2,251	2814	3,376	3,939	4,502	>4502
6	2,581	3226	3,871	4,516	5,162	>5162
7	2,911	3639	4,366	5,094	5,822	>5822
8	3,241	4051	4,861	5,671	6,482	>6482

Rev. 1/17/2013

I attest that all statements attached to this document are true and correct to the best of my knowledge. I have reported all income sources to **Tazewell County Dental Center** and have correctly listed all dependents in the household. I understand this information may include medical or non-medical information including such collateral sources as banks, employers, and insurance companies. If any of the information changes, I understand I am to report this to the Financial Coordinator at the next visit. This procedure must be updated yearly. Should it come to our knowledge that the information provided is fraudulent or misleading, the patient will not be allowed to use the Sliding Fee Scale and will placed at 100% of fee as long as they remain a patient.

X _____ Date _____
(Signature of Patient/Parent/Guardian)

TCHD Staff Member: _____