Frontera Healthcare Network

CERTIFICATION OF INCOME

Name: _____ Date of Birth: _____ Date: _____

I understand that the health center will determine my eligibility based on these figures. I further understand that if I have given inaccurate information it will be grounds for the health center to disallow my discount and charge me for any discounts received based upon the false information.

Signature _____

MEMBERS OF HOUSEHOLD: (IF APPLYING FOR SLIDING SCALE)

Name	Date of Birth	M/F	Relation

Source of Income	Amount

Yearly Amount _____ # of people in household _____ Code _____

Staff Signature _____ Date _____ Exp. Date _____

Federal Register, January 18, 2018

DISCOUNT SCHEDULE BASED ON 2018 HHS FEDERAL POVERTY INCOME LIMITS

Family Size	PATIENT PORTION									
	100% and Below		101%-150%		151%-175%		176%-200%		201%	
	Medical	$ 20	$ 25		$ 30		$ 35		$ -	
	Behavioral	$ 5	$ 10		$ 15		$ 20		$ -	
	Dental	$ 35	$ 40		$ 45		$ 50		$ -	
	(Level I and II)									
	From	To	From	To	From	To	From	To	From	To
1	$ -	$12,140	$12,141	$18,210	$18,211	$21,245	$21,246	$24,280	$24,281	>
2	$ -	$16,460	$16,461	$24,690	$24,691	$28,805	$28,806	$32,920	$32,921	>
3	$ -	$20,780	$20,781	$31,170	$31,171	$36,365	$36,366	$41,560	$41,561	>
4	$ -	$25,100	$25,101	$37,650	$37,651	$43,925	$43,926	$50,200	$50,201	>
5	$ -	$29,420	$29,421	$44,130	$44,131	$51,485	$51,486	$58,840	$58,841	>
6	$ -	$33,740	$33,741	$50,610	$50,611	$59,045	$59,046	$67,480	$67,481	>
7	$ -	$38,060	$38,061	$57,090	$57,091	$66,605	$66,606	$76,120	$76,121	>
8	$ -	$42,380	$42,381	$63,570	$63,571	$74,165	$74,166	$84,760	$84,761	>
9	$ -	$46,700	$46,701	$70,050	$70,051	$81,725	$81,726	$93,400	$93,401	>
10	$ -	$51,020	$51,021	$76,530	$76,531	$89,285	$89,286	$102,040	$102,041	>
11	$ -	$55,340	$55,341	$83,010	$83,011	$96,845	$96,846	$110,680	$110,681	>
12	$ -	$59,660	$59,661	$89,490	$89,491	$104,405	$104,406	$119,320	$119,321	>
13	$ -	$63,980	$63,981	$95,970	$95,971	$111,965	$111,966	$127,960	$127,961	>
14	$ -	$68,300	$68,301	$102,450	$102,451	$119,525	$119,526	$136,600	$136,601	>
15	$ -	$72,620	$72,621	$108,930	$108,931	$127,085	$127,086	$145,240	$145,241	>

Note: Patient will not be denied services based upon the documented inability to pay

_____ By signing this line, I refuse to provide financial information and that I am aware that I am not eligible for any discounts