ETSUHealth
COLLEGE OF NURSING

Medical Sliding Fee

Schedule of Income Thresholds Based upon 2023 Federal Poverty Guidelines (January 19, 2023)
*if actual charges are less than amounts shown, patient pays lesser amount

Annual Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty

Family Unit Size	$25.00 Nominal Fee	(A) $40.00	(B) $50.00	(C) $60.00	(D) $70.00	100% Pay No Discount
Poverty	**≤100% FPL**	**≥ 101-124% FPL**	**≥ 125-149% FPL**	**≥ 150-174% FPL**	**≥ 175-200% FPL**	**≥ 201% FPL**
1	0 - $14,580	$14,581 - $18,224	$18,225 - $21,869	$21,870 - $25,514	$25,515 - $29,305	$29,306+
2	0 - $19,720	$19,721 - $24,649	$24,650 - $29,579	$29,580 - $34,509	$34,510 - $39,637	$39,638+
3	0 - $24,860	$24,861 - $31,074	$31,075 - $37,289	$37,290 - $43,504	$43,505 - $49,968	$49,969+
4	0 - $30,000	$30,001 - $37,499	$37,500 - $44,999	$45,000 - $52,499	$52,500 - $60,299	$60,300+
5	0 - $35,140	$35,141 - $43,924	$43,925 - $52,709	$52,710 - $61,494	$61,495 - $70,631	$70,632+
6	0 - $40,280	$40,281 - $50,349	$50,350 - $60,419	$60,420 - $70,489	$70,490 - $80,962	$80,963+
7	0 - $45,420	$45,421 - $56,774	$56,775 - $68,129	$68,130 - $79,484	$79,485 - $91,294	$91,295+
8	0 - $50,560	$50,561 - $63,199	$63,200 - $75,839	$75,840 - $88,479	$88,480 - $101,625	$101,626+

Note: The income ceiling for the nominal fee pay class is equal to the federal poverty level.
For families/households with more than 8 persons, add $5,140 for each additional person

Monthly Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty

Family Unit Size	$25.00 Nominal Fee	(A) $40.00	(B) $50.00	(C) $60.00	(D) $70.00	100% Pay No Discount
Poverty	**≤100% FPL**	**≥ 101-124% FPL**	**≥ 125-149% FPL**	**≥ 150-174% FPL**	**≥ 175-200% FPL**	**≥ 201% FPL**
1	0 - $1,215	$1,216 - $1,518	$1,519 - $1,822	$1,823 - $2,126	$2,127 - $2,442	$2,443+
2	0 - $1,643	$1,644 - $2,054	$2,055 - $2,464	$2,465 - $2,875	$2,876 - $3,303	$3,304+
3	0 - $2,072	$2,073 - $2,589	$2,590 - $3,107	$3,108 - $3,625	$3,626 - $4,164	$4,165+
4	0 - $2,500	$2,501 - $3,124	$3,125 - $3,749	$3,750 - $4,374	$4,375 - $5,024	$5,025+
5	0 - $2,928	$2,929 - $3,660	$3,661 - $4,392	$4,393 - $5,124	$5,125 - $5,885	$5,886+
6	0 - $3,357	$3,358 - $4,195	$4,196 - $5,034	$5,035 - $5,874	$5,875 - $6,746	$6,747+
7	0 - $3,785	$3,786 - $4,731	$4,732 - $5,677	$5,678 - $6,623	$6,624 - $7,607	$7,608+
8	0 - $4,213	$4,214 - $5,266	$5,267 - $6,319	$6,320 - $7,373	$7,374 - $8,468	$8,469+

Note: The monthly schedule is equal to the annual schedule divided by 12 months.

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SLIDING FEE DISCOUNT APPLICATION

It is the policy of ETSU College of Nursing to provide essential services regardless of ability to pay. Discounts are offered on a sliding fee scale based on family size and annual income. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a sliding fee discount.

Sliding fee discounts apply to services within our health centers only. Discounts do not apply to services procured from external services providers such as: reference laboratory testing, medications, hearing aids and other services. Please ask your healthcare provider if a particular service is or is not subject to the sliding fee discount. Additional charges may apply to services procured from external service providers.

If you **do not** wish to apply for the sliding fee discount at this time, please indicate the same.

☐ I do not wish to apply for the sliding fee discount at this time. I understand I may apply at any time by requesting an application at the front desk.

_____ _____

Signature of Patient or Legally Authorized Representative Date

If you **do** want to apply for the sliding fee discount please complete the below.

SECTION 1: HEAD OF HOUSEHOLD INFORMATION			
Printed Name		**Date of Birth**	**Phone (include area code)**
Address (Number and Street, Apt. No.)	**City**	**State**	**Zip**
Please list the total number of people in your family:			

SECTION 2: DEPENDENT INFORMATION Please list all dependents.			
Printed Name	**Date of Birth**	**Printed Name**	**Date of Birth**
Printed Name	**Date of Birth**	**Printed Name**	**Date of Birth**
Printed Name	**Date of Birth**	**Printed Name**	**Date of Birth**

Patient Printed Name: _____ Date of Birth: _____

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SECTION 3: HOUSEHOLD INCOME INFORMATION You may report your income in an annual or monthly amount. Please circle which option your reporting below.				
Annual or Monthly	**Self**	**Spouse**	**Other**	**Total Amount**
Gross Wages, salaries, tips, etc.				$0.00
Income from business, self-employment, and dependents				$0.00
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payment, survivor benefits, pension or retirement income, 1040 tax form				$0.00
Interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources				$0.00
Total Annual/Monthly Gross Income *Gross income is before taxes and deductions				**$0.00**

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before your sliding fee application is approved. Failure to complete this application and/or supply any needed documents to verify income within 3 business day of the date of service will result in the patient being charged the full fee for services rendered.

By signing below, I certify the information provided on this application is true and complete to the best of my knowledge. I understand that completion of this application does not guarantee a discount will be applied. If I am not approved for a discount I understand I will be responsible for the full amount for any services I receive.

_____ _____

Signature of Patient or Legally Authorized Representative Date

OFFICE USE ONLY				
Checklist	**☑**	**Awaiting Proof of Income**		**☑**
Verified Monthly Income: **Total:**		**Proof of Income Requested:** **Date:**		
Number in Household: **Total:**		**Income Requirement Discussed with Patient:** **Date:**		
Proof of Income Received: **Type:**		**Notes:**		
Sliding Fee Discussed with Patient: **Sliding Fee Scale Category:**				
Recertification Date:		**Staff Signature:**	**Date:**	

Patient Printed Name: _____ Date of Birth: _____