COASTAL COMMUNITY HEALTH

# PEDIATRIC PACKET

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: ___
STREET ADDRESS: _____ CITY: _____ STATE: ____
PHONE: _____ DOB: _____ AGE:____ SEX:____ SOC.SEC.NO._____

MOTHER'S FULL NAME: _____ CELL NO.: _____

FATHER'S FULL NAME: _____ CELL NO: _____

MOTHER'S EMPLOYER: _____ PHONE NO.: _____

FATHER'S EMPLOYER: _____ PHONE NO.: _____

**INSURANCE/PAYMENT INFORMATION:** ****SELF PAY: YES ○ NO ○**

PRIMARY INS: _____ SUBSCRIBER: _____ ID:_____

SECONDARY INS: _____ SUBSCRIBER:_____ ID: _____

TERTIARY INS: _____ SUBSCRIBER: _____ ID: _____

CCHS OFFERS A SLIDING DISCOUNT FEE PROGRAM, WOULD YOU LIKE TO APPLY? **YES ○ NO ○**

**PATIENT WEB PORTAL:**

CCHS OFFERS A FREE AND SECURE ONLINE PORTAL TO VIEW MEDICAL RECORDS, REQUEST REFILLS, MESSAGE YOUR PROVIDER AND MANY OTHER GREAT FEATURES. ALL IT TAKES IS A CURRENT E-MAIL ADDRESS.

PERSONAL EMAIL ADDRESS: _____@_____
Once we enter your e-mail address into the system you will receive log-in instructions via your e-mail.
○ PLEASE CHECK HERE IF YOU DO NOT WANT ACCESS TO THE WEB PORTAL OR YOU DO NOT HAVE A PERSONAL E-MAIL ACCOUNT.

**WHO IS YOUR PREFERRED PHARMACY?**

_____

## STATISTICAL ANALYSIS/STRUCTURED DATA:

Race: [ ] Refuse [ ] Asian Indian [ ] Chinese [ ] Filipino [ ] Japanese [ ] Korean [ ] Vietnamese [ ] Other Asian [ ] Guamantan or Chamorro [ ] Samoan [ ] Other Pacific Islander [ ] African-American [ ] Caucasian [ ] American Indian/Alaska Native [ ] Native Hawaiian [ ] More than one race [ ]

**ETHNICITY:** ( ) HISPANIC/LATINO ( ) NON-HISPANIC/LATINO ( ) REFUSE TO REPORT

**SEXUAL IDENTITY:** ( ) STRAIGHT (NOT GAY OR LESBIAN) ( ) BISEXUAL ( ) GAY OR LESBIAN ( ) SOMETHING ELSE ( ) DON'T KNOW ( ) REFUSE TO REPORT

**TYPE OF RESIDENCE:** ( ) OWN ( ) RENT ( ) SHELTER ( ) HOMLESS {STREET ( ) YES ( ) NO) ( ) TRANSITIONAL ( ) FRIENDS ( ) FAMILY **PUBLIC HOUSING:** ( ) YES ( ) NO

**HOW DID YOU HEAR ABOUT US?:** ( ) EMPLOYER( ) FAMILY ( ) FRIEND ( ) NEWSPAPER ( )PROVIDER ( ) SCHOOL ( ) GATEWAY ( ) SAFE HARBOR ( ) COMMUNITY EVENT ( ) WEBSITE ( ) FACEBOOK ( ) OTHER ( ) CMAP

**ANNUAL FAMILY INCOME:** ( ) $0-13,590 ( ) $13,591-18,075 ( ) $18,076-22,695 ( ) $22,696-227,180

**HOUSEHOLD SIZE:** HOW MANY PEOPLE LIVE IN YOUR HOUSHOLD _____

## CONSENT TO TREAT A MINOR:

I, _____ (Parent/Guardian) of _____, DOB: _____ hereby authorize the providers of Coastal Community Health Services, Inc. to diagnose and treat my minor child as they deem advisable. I understand treatment may involve diagnostic procedures, immunizations, and medications.

_____ _____

PARENT/GUARDIAN DATE

_____ _____

CCHS STAFF WITNESS DATE

## AUTHORIZATION TO PAY:

I hereby authorize Coastal Community Health Services, Inc. permission to bill my insurance company and receive payment of benefits otherwise payable to me for treatment rendered to my minor child. I understand that any balance not paid by my insurance company is my full responsibility. I further understand that Coastal Community Health Services, Inc. makes no claims as to what my insurance company will pay. Every policy is individual and it is my responsibility to know what my coverage is. I further understand that if my insurance lapses or I am otherwise uninsured I am fully responsible for all charges for services rendered.

_____ _____

PARENT/GUARDIAN DATE

COASTAL COMMUNITY HEALTH

# NOTICE OF PRIVACY PRACTICES

## Your Information. Your Rights. Our Responsibilities.

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information.* ***Please review it carefully.***

### Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

### Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

**Our Uses and Disclosures**

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Through our patient portal; all of your health information is accessible by you when you sign up with e-mail to access the patient portal.

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

**Please sign to acknowledge that you have had an opportunity to receive this Notice and to ask questions regarding its contents. Signing this Acknowledgment form in no way affects the care you will receive.**

Print Name _____

Signature _____

Date _____ ,

COASTAL COMMUNITY HEALTH

# TREATMENT AUTHORIZATION AND AGREEMENT

Patient Name: _____ Date of Birth: _____

- I hereby voluntarily request, consent to, and authorize Coastal Community Health Services' doctors, nurse practitioners, physician assistants, behavioral health clinicians, dental providers or other practitioners to provide confidential medical, family planning, dental and surgical treatment including, but not limited to, diagnostic procedures, lab testing, and administration of medications as deemed necessary and advisable.
- I further understand and acknowledge that an HIV test may be performed upon me or my child, without written consent, under the circumstances that a Coastal Community Health Services employee sustains a percutaneous mucous membrane, or other exposure, to my blood or other bodily fluids.
- I understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believed to be spread by person-to-person contact. I recognize that the staff of Coastal Community Health Services has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I recognize and accept the risk of becoming infected by virtue of seeking services in-person at Coastal Community Health Services.

**AGREEMENT TO PAY FOR SERVICES**

- I authorize Coastal Community Health Services to release my medical necessary information to Medicare, Medicaid, or other insurance carriers to process claims and further authorize payment of medical benefits payable directly to CCHS.
- I understand that CCHS will file and complete necessary steps to collect my insurance payment.
- I understand that I am responsible for any account balance that is not covered by insurance or for any services rendered at Coastal Community Health Services according to the sliding fee scale. This includes any deductibles or co-payment portions of my bill after insurance payment.

**COASTAL COMMUNITY HS SCREENS EVERY PATIENT FOR POTENTIAL FURTHER DISCOUNTS RELATED TO SERVICES. THIS INFORMATION CAN HELP YOU TO DECREASE YOUR COPAY LEVEL OR LEVEL OF YOUR DEDUCTIBLE IF YOUR POLICY INCLUDES SUCH PROVISIONS.**

**HOUSEHOLD SIZE _____**

**HOUSEHOLD INCOME: { } $0-14,580 { } $14,581-19,391{ } $19,392-24,349[ } $24,350-29,160{ } >29,161-36,450**

**Decline release of income information** ☐

**Authorization and Consent to Access, Use and Disclosure of Protected Health Information to/from Coastal Community Health Services**

- I consent to and authorize Coastal Community Health Services to store my personal protected health information in an electronic health record through eClinical Works.
- I consent to Coastal Community Health Services and its designees accessing through and/or disclosing my individually identifiable health information (medical and dental) to eClinical Works.

_____ Date: _____

Patient/Guardian Signature

*If signing as a legal guardian, you are verifying that you are giving consent to the above listed conditions for your minor child.

COASTAL COMMUNITY HEALTH

| Shoppers Way Location | Ellis Street Location | Shellman Bluff Location | Townsend (Elulonia) | Saint Marys Location |
|---|---|---|---|---|
| (912) 275-8028 (P) | 912-289-2006 (P) | 912-623-4755 (P) | 912-574-5277 (P) | 912-574-5084(P) |
| (912) 289-2085 (F) | 912-289-2014 (F) | 912-549 -1040 (F) | 912-228-5007 (F) | |

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name: _____ Social Security #:_____

**IF YOU HAVE ANY DOCTORS THAT YOU WOULD LIKE US TO REQUEST MEDICAL RECORDS FROM, PLEASE FILL IN THE LINE BELOW WITH THEIR NAME. PLEASE REQUEST ADDITIONAL FORMS IF NEEDED.**

I request and authorize _____ to release my healthcare information to
(Previous Doctor's Name/ Clinic Name)

**Coastal Community Health Services, INC.**

**Please check this box if you would like to authorize both people/ organizations listed above to share authorized information.**

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- o All Healthcare information
- o Other: _____

**Definition:** Sexually Transmitted Disease (STD) is defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia , non -specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) , and gonorrhea.

- o Yes I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive,
- o No to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

- o Yes I authorize the release of any records regarding drug, alcohol, or mental health treatment
- o No to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

COASTAL COMMUNITY HEALTH

## Permission to Share My Personal Health Information (HIPAA)

Patient Name: _____ Birth Date: _____

You have the right to control who can see private information about your health (Protected Health Information). Use this form to give permission for a trusted friend or family member to get private information about your health care. **You can change these permissions at any time by letting us know in writing.**

_____ **NO,** do not share my Protected Health Information with anyone.
_____ **YES**, I give permission for the person/people listed below to access my private health information:

**Name:**_____

**This person can (INITIAL all the permissions you want to give):**

____ Make or cancel appointments for me
____Talk with my doctor or health staff on my behalf
____ Handle my paperwork, labs, and prescriptions
____ See my complete medical records
____See my financial records

**Name:**_____

**This person can (INITIAL all the permissions you want to give):**

____ Make or cancel appointments for me
_____Talk with my doctor or health staff on my behalf
_____Handle my paperwork, labs, and prescriptions
____ See my complete medical records
____ See my financial records

_____ _____
Signature Date

## Sliding Fee Scale Discount Application

COASTAL COMMUNITY HEALTH

NEW APPLICATION ☐ RE-CERTIFICATION ☐

### APPLICANT INFORMATION

| FULL NAME (First, MI, Last) | DATE OF BIRTH |
|---|---|
| | |

***CHECK HERE ONLY IF YOU **DO NOT** WANT TO APPLY FOR THE SLIDING FEE SCALE DISCOUNT***

I have been given the opportunity to apply for the Coastal Community Health Center, Inc. (CCHS) discount services sliding fee schedule.

☐ ***I DO NOT wish to apply for the CCHS discount services sliding fee program at this time.***

| SIGNATURE OF PATIENT OR GUARANTOR | DATE |
|---|---|
| | |

### GENERAL INFORMATION

The questions on this form will only be used to gather information about you and your family, so we can better meet your medical, dental, behavioral health, and/or vision needs (if you are insured, you may qualify for discounted copays or deductibles. If you are uninsured, you may qualify for discounted fees for services provided.) **This information will not be used to withhold or deny services.**

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Are you covered under Medicaid, Medicare, and/or any other insurance? |
| ☐ Yes | ☐ No | Are you unemployed? |
| ☐ Yes | ☐ No | Are you disabled? |

### HOUSEHOLD INFORMATION

Please include yourself, your spouse/partner, and all dependents receiving 50% or more of their support from the head of household.

| Name | Date of Birth | Relationship to Applicant | Insurance | Insurance Type |
|---|---|---|---|---|
| | | Applicant/Self | ☐ Yes ☐ No | ☐ Medicaid ☐ Medicare ☐ Other:_____ |
| | | | ☐ Yes ☐ No | ☐ Medicaid ☐ Medicare ☐ Other:_____ |
| | | | ☐ Yes ☐ No | ☐ Medicaid ☐ Medicare ☐ Other:_____ |
| | | | ☐ Yes ☐ No | ☐ Medicaid ☐ Medicare ☐ Other:_____ |
| | | | ☐ Yes ☐ No | ☐ Medicaid ☐ Medicare ☐ Other:_____ |
| | | | ☐ Yes ☐ No | ☐ Medicaid ☐ Medicare ☐ Other:_____ |

### DECLINATION OF DOCUMENTATION REQUIREMENTS

If you aren't able to comply with the documentation requirements, you are required to provide your cash income amount below, sign the applicant certification statement, and provide a letter from your employer on company letterhead that verifies the income amount you provide. **Failure to complete this information** will result in the denial of your application for a sliding scale discount.

| | | | | | |
|---|---|---|---|---|---|
| MY CASH INCOME IS: | $ | ☐ Weekly | ☐ Bi-Weekly | ☐ Monthly | ☐ Other: |
| CURRENT EMPLOYER: | | | | | |

### APPLICANT CERTIFICATION STATEMENT

I certify that I have no other way to document my income, and all of the above information is accurate. I understand this information is to be used to determine eligibility for the CCHS Sliding Fee Discount Program. I understand CCHS officials may verify information provided on this form.

| SIGNATURE OF PATIENT | DATE |
|---|---|
| | |

## Sliding Fee Scale Discount Application

### INCOME VERIFICATION

Please enter your **gross income** *(the dollar amount received before taxes are taken out)* in the table below. Household income includes all income generated by everyone in the household. Proof of income is required before the discount goes into effect.

| Type of Income (Before Taxes or Deductions) | NAME OF PERSON RECEIVING INCOME #1 | NAME OF PERSON RECEIVING INCOME #2 | NAME OF PERSON RECEIVING INCOME #3 | HOW OFTEN DO YOU RECEIVE THIS INCOME? |
|---|---|---|---|---|
| Work Wages | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Cash Wages | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Disability Income (non-military) | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Social Security | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Unemployment | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Worker's Comp | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Child Support | Not considered | Not considered | Not considered | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Alimony | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Tips | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Self-Employment | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Retirement | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Military Disability | Not considered | Not considered | Not considered | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |
| Other Income | $ | $ | $ | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other: |

I understand that if I provide false information, I will be disqualified from the program, and all charges will be due in full immediately. I understand that I will be required to submit documentation of proof of income (1 month / 4 weeks of paystubs, prior year tax return, SSA letter, unemployment award letter, letter from employer, etc.). I understand that any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts. By signing this form, I certify under penalty of perjury under the laws of the State of Georgia that the above information is true and correct, and I assume the responsibility of contact CCHS should any changes to my financial or insurance status occur.

| **APPLICANT SIGNATURE** | **DATE** |
|---|---|
| | |

**FOR OFFICE USE ONLY** (to be calculated once proof of income is received)

| | | | |
|---|---|---|---|
| TOTAL NUMBER IN HOUSEHOLD: | | SLIDING FEE SCALE: ☐ A ☐ B ☐ C ☐ D ☐ E | |
| GROSS INCOME AMOUNT #1: | $ | DATE OF COMPLETED APPLICATION: | |
| GROSS INCOME AMOUNT #2: | $ | BACKDATE DISCOUNT TO: | |
| GROSS INCOME AMOUNT #3: | $ | INITIALS OF CCHS REPRESENTATIVE: | |
| **TOTAL** GROSS INCOME AMOUNT: | $ | ADMINISTRATIVE APPROVAL IF BACKDATE IS MORE THAN 14 DAYS: | |
| TOTAL ANNUAL HOUSEHOLD INCOME | $ | | |

# STANDARD SERVICES SLIDING FEE SCHEDULE FOR QUALIFIED PATIENTS

| | % of FPL | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | |
| | ≤100% (Nominal Fee) | 101%-133% | >133%-167% | >167%-200% | >200%-250% | >250% |
| Family Size | Annual Income | | | | | |
| 1 | ≤$15,060 | 15,061 - 20,030 | 20,031 - 25,150 | 25,151 - 30,120 | 30,121 - 37,650 | ≥$37,651 |
| 2 | ≤$20,440 | 20,441 - 27,185 | 27,186 - 34,135 | 34,136 - 40,880 | 40,881 - 51,100 | ≥$51,101 |
| 3 | ≤$25,820 | 25,821 - 34,341 | 34,342 - 43,119 | 43,120 - 51,640 | 51,641 - 64,550 | ≥$64,551 |
| 4 | ≤$31,200 | 31,201 - 41,496 | 41,497 - 52,104 | 52,105 - 62,400 | 62,401 - 78,000 | ≥$78,001 |
| 5 | ≤$36,580 | 36,581 - 48,651 | 48,652 - 61,089 | 61,090 - 73,160 | 73,161 - 91,450 | ≥$91,451 |
| 6 | ≤$41,960 | 41,961 - 55,807 | 55,808 - 70,073 | 70,074 - 83,920 | 83,921 - 104,900 | ≥$104,901 |
| 7 | ≤$47,340 | 47,341 - 62,962 | 62,963 - 79,058 | 79,059 - 94,680 | 94,681 - 118,350 | ≥$118,351 |
| 8* | ≤$52,720 | 52,721 - 70,118 | 70,119 - 88,042 | 88,043 - 105,440 | 105,441 - 131,800 | ≥$131,804 |
| MEDICAL VISIT ** | $ 25.00 | $55 | $75 | $95 | 100% of Charges | 100% of Charges |
| DENTAL VISIT *** | $ 50.00 | $70 | $100 | $140 | 100% of Charges | 100% of Charges |
| DENTAL PREVENTATIVE (cleaning) | $ 40.00 | $60 | $90 | $110 | 100 % of Charges | 100 % of Charges |
| LAB ONLY VISIT | $ 10.00 | $20 | $30 | $40 | 100 % of Charges | 100 % of Charges |
| VISION EXAM | $ 10.00 | $20 | $30 | $ 40 | 100 % of Charges | 100 % of Charges |
| IN-HOUSE PHARMACY DISPENSING FEES | $ 5.00 | $10 | $12 | $ 14 | NO DISCOUNT | NO DISCOUNT |
| CONTRACT PHARMACY DISPENSING FEES | $ 9.00 | $11 | $13 | $ 15 | NO DISCOUNT | NO DISCOUNT |
| FAMILY PLANNING VISIT (TITLE X) | $ - | $20 | $45 | $65 | $85 | 100 % of Charges |

* *For family units with more than 8 members, add $5,380 for each additional member. 2024 FPL figures are used*

** *Limited labs included in the visit fee.*

*** ***Dental lab (crowns, bridges, dentures, night guards, etc.) are not subject to standard fee. Cosmetic elective procedures are priced separately. Additional charges apply.***

**** *340B Dispensing Fee only (uninsured).* ***Cost of medication is charged separately.***

***HOUSEHOLD INCOME*** *Combined gross income of all members for a household who are 18 years old and older. Alternatively, household income is the combined income of all members of a household who jointly apply for Sliding Fee Scale Discount. Household income includes any sourece of normally taxable income of the applying party and it includes wages, salary, social security benefits, disability income, and any other payments. Food stamps, child support, SNAP programs or any compensation not defined as taxable income are excluded from the calculation. Patient's assets (such as savings, IRA, 401(k)) are not considered income.*

***HOUSEHOLD SIZE*** *Is the number of persons living in the household who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that another person may reside at the common residence and not be considered as par of household unit (example: roomate).*

*Effective 02/01/2024*