A, B, C, D or E
Expires:

MCHC HEALTH CENTERS

Patient Financial Application/Screening

☐ **Payment Plan** ☐ **Sliding Scale** **Account #** _____

☐ **Hillside** ☐ **Dora St.** ☐ **Lakeview** ☐ **Little Lake**

Patient Name:_____ Date of Birth:_____

Patient Social Security #:_____

Responsible Person:_____ Date of Birth:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD – PATIENT, SPOUSE AND CHILDREN UNDER 18 – FOR WHOM YOU HAVE FINANCIAL RESPONSIBILITY

Name	**Date of Birth**	**Gross Monthly Income**
1.		
2.		
3.		
4.		
5.		
	Total Monthly	

I/We do declare my/our monthly gross household income is: **$**_____

Payment Plan

Total $_____ Down payment $_____

Monthly payment $_____ for _____ months

By signing below, I agree that I am financially responsible for treatment I receive. I declare under penalty of perjury that the answers and documents I have provided are correct to the best of my knowledge. I understand that payment is required at the time of service and, if payments are not made in a timely manner, then the unpaid balance may be turned over to a collection agency.

Sliding-scale patients needing diagnostic services: *I authorize MCHC to release this information to another health care provider in order to qualify for their charity care program for diagnostic tests ordered by MCHC providers.*

_____ _____ _____

Patient's Signature *Date* *Patient Financial Services Representative*

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MCHC HEALTH CENTERS

Worksheet

For MCHC Staff Use Only:

Family Size: _____

Total Monthly Gross Income_____ **Total Annual Gross Income** _____

Sliding Scale: _____**Expires:**_____ _____

PFS Representative (Name Printed)

2025 Federal Poverty Guidelines

Chart showing family size and annual income,
to be used for determining patient sliding fee discount eligibility.

Sliding Scale:	**A***	**B**	**C**	**D**	**E**	**F**
Incomes between:	≤ 100%	101% - 138%	139% - 150%	151% - 175%	176% - 200%	>200%
Family Size:						
1	$15, 650	$21,597	$23,475	$27,388	$31,300	> $31,301
2	$21,150	$29,187	$31,725	$37,013	$42,300	>$42,301
3	$26,650	$36,777	$39,975	$46,638	$53,300	>$53,301
4	$32,150	$44,367	$48,225	$56,263	$64,300	>$64,301
5	$37,650	$51,957	$56, 475	$65,888	$75,300	>$75,301
6	$43,150	$59, 547	$64,725	$75,513	$86,300	>$86,301
7	$48,650	$67,137	$72,975	$85,138	$97,300	>$97,301
8	$54,150	$74,727	$81,225	$94,763	$108,300	>$108,301
For families/households with more than 8 persons	add $5,500 for each additional person					