Fairfax Medical Facilities, Inc.
Sliding Fee Discount Program Application

It is the policy of Fairfax Medical Facilities, Inc. to provide essential services regardless of the patient's ability to pay. Discounts are offered 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 discount. The sliding fee discount will apply to services within the Fairfax Medical Facilities, Inc. scope of project, but not those services, equipment and/or supplies that are purchased from outside, (other discounts may apply as indicated in the Sliding Fee Discounts on Outside Testing policy). This application must be completed every 12 months or if your financial situation changes.

Name of Head of Household		Place of Employment		
Street	PO Box	City	State	Zip
Home Phone	Mobile Phone	Email Address		

Section A

If applying for sliding fee-scale, please circle the income range that best describes your yearly household income and current number of people in household.
I choose not to disclose my financial information. By choosing not to disclose my income, I accept financial responsibility for all fees incurred.

Patient Signature_____

Sliding Fee Classification	A	B	C	D	E	F
Federal Poverty Level*	**< = 100%**	**125%**	**150%**	**175%**	**200%**	**>200%**
Patient Payment Responsibility	Nominal Fee	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Family Size	**Annual Income**	**Annual Income**	**Annual Income**	**Annual Income**	**Annual Income**	**Annual Income**
1	0 - 15,650	15,651 - 19,562	19,563 - 23,475	23,476 - 27,387	27,388 - 31,300	31,301+
2	0 - 21,150	21,151 - 26,437	26,438 - 31,725	31,726 - 37,012	37,013 - 42,300	42,301+
3	0 - 26,650	26,651 - 33,312	33,313 - 39,975	39,976 - 46,637	46,638 - 53,300	53,301+
4	0 - 32,150	32,151 - 40,187	40,188 - 48,225	48,226 - 56,262	56,263 - 64,300	64,301+
5	0 - 37,650	37,651 - 47,062	47,063 - 56,475	56,476 - 65,887	65,888 - 75,300	75,301+
6	0 - 43,150	43,151 - 53,937	53,937 - 64,725	64,726 - 75,512	75,513 - 86,300	86,301+
7	0 - 48,650	48,651 - 60,812	60,813 - 72,975	72,976 - 85,137	85,138 - 97,300	97,301+
8	0 - 54,150	54,151 - 67,687	67,688 - 81,225	81,226 – 94,762	94,763 - 108,300	108,301+
FOR EACH PERSON	5,500					
***BASED ON THE 2025 HHS POVERTY GUIDELINES (https://aspe.hhs.gov/poverty-guidelines)**						

Sliding Fee Classification	A	B	C	D	E	F
Federal Poverty Level*	< = 100%	125%	150%	175%	200%	>200%
Medical Visit	$30	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Mental/ Behavioral Health Visit	$25	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Dental Visit	$40	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Dental – Specialty (root canal, crowns, bridges, dentures) + associated lab fees	$140	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Laboratory	$20	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Radiology	$35	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge
Injections	$15	20% of Standard Charge	40% of Standard Charge	60% of Standard Charge	80% of Standard Charge	100% of Standard Charge

To apply for the Sliding Fee Program, you must provide appropriate documentation.
Applicants must provide customary forms as proof of income. Acceptable forms of proof for determining income include, but are not limited to, the following:

- **Income Tax Return** – A signed copy of the most recent tax return showing adjusted gross income (AGI).
- **Paycheck Stubs** –Two consecutive paycheck stubs indicating gross pay, with year-to-date income provided.
- **Self-Employed** - If you are self-employed, tax forms from current year and a profit and loss statement.
- **Agency Letter** – A letter from the Social Security Administration, Veterans Administration, or Social Service Agency (i.e., AFDC, Food Stamps, WIC) indicating income level.
- **Unemployment Verification** – Paperwork from the Employment Securities Commission (ESC), proving unemployment status and the amount of unemployment compensation being received.
- **Court Documents** – Official documents citing child support, or alimony as awarded by a judge accompanied by a statement of child support enforcement stating amount received **In the situation of spousal separation, a legal document such as a legal separation or divorce filing will be requested from the patient; but not required if self-declared.*
- **Official Paperwork** – Paperwork documenting retirement, disability, and/or SSI benefits.

- **Employer Letter** – For those not receiving an actual paycheck, a letter from the patient's employer detailing current gross income and frequency of pay periods may be accepted. Contact information on the company letterhead must be provided so that the information can be verified.
- **No Job/Other Income Source –** A current-dated letter from an agency, or past employer, who knows the situation and is NOT living with the applicant, which includes the writer's name, address, and phone number.
- **Fixed Income Statement** (example: pension, social security or bank statement showing deposits).
- **Signed Letter** - From a minister, law enforcement, City Hall, or lawyer, verifying financial status, housing situation, and how you cover expenses.
- **Student Grant Information**
- **Self-Declaration** - Is acceptable if no other information can be provided, may only be used in special circumstances, and requires approval of CFO or CEO (per policy).

You MUST provide proof of address by presenting at least one of the items listed below:

- Driver's license or state issued ID card – The driver's license or state issued ID MUST have a current address
- Utility bill
- Pay stubs – MUST have the current address listed.

Section B

Please complete table for individuals in the household (DO NOT list individuals that the responsible party is not LEGALLY responsible):

Last Name, First Name	DOB	Does Individual Have Health Coverage	Insurance Carrier: Medicaid, Medicare, Blue Cross, CHIP, etc.	Policy/ID Numbers
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		

Section C

Please list income of all adult household members who are employed:

Person Employed	Company Name	Income Before Taxes	How Often?
		$	□Biweekly □Monthly □Yearly
		$	□Biweekly □Monthly □Yearly
		$	□Biweekly □Monthly □Yearly

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly
Income from business, self-employment, and dependents	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly
Other Income	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly
Total Income	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly	□Biweekly □Monthly □Yearly

NOTE: Appropriate documentation is required before a discount is approved.

☐ I am currently unemployed and have no other sources of income. May only be used in special circumstances and requires approval of CFO or CEO. (Self-Declaration)

I certify that the family size and income information shown above is correct.

_____
Name (Print)

_____ _____
Signature Date

FMFI OFFICE USE ONLY

Income $: _____ Monthly or Yearly Sliding Fee Scale Discount: _____ %

Sliding Fee Classification (Circle One): A B C D E F
□ Does not Qualify □ Incomplete Application □ Unknown

FMFI Representative Signature: _____ Date: _____

- **Consultation Conducted:**

Date: _____ Name of Family Member: _____

√	Process	Date	Initial
	Identification/Address: Driver's license, utility bill, employment ID		
	Income: Prior year tax return, two consecutive pay stubs		
	Insurance: Insurance Cards		
	SFDP application scanned into information system/patient record		
	Discount applied to account in information system		
	Household informed of application status and eligibility		
	Information on services provided (Primary care, dental, drug program, etc.)		